HEALTH CARE COST CONTAINMENT UNDER H.R. 3600, THE "HEALTH SECURITY ACT"

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

DECEMBER 16, 1993

Serial 103–56

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

77–602 CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-044197-8

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CONTENTS

HEALTH CARE COST CONTAINMENT UNDER H.R. 3600, THE "HEALTH SECURITY ACT"

THURSDAY, DECEMBER 16, 1993

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The committee met, pursuant to call, at 10:01 a.m., in room 1100, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the committee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
TUESDAY, NOVEMBER 23, 1993

PRESS RELEASE #16
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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THE HONORABLE DAN ROSTENKOWSKI (D., ILL.), CHAIRMAN, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON HEALTH CARE COST CONTAINMENT UNDER H.R. 3600, THE "HEALTH SECURITY ACT"

The Honorable Dan Rostenkowski (D., Ill.), Chairman, Committee on Ways and Means, U.S. House of Representatives, today announced that the Committee will hold a hearing on President Clinton's health care cost containment proposals included in H.R. 3600, the Health Security Act. The hearing will be held on Thursday, December 16, 1993, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.

In announcing the hearing, Chairman Rostenkowski said: "Rapidly rising costs are one of the major problems of our current system for financing and providing health care. I strongly support the President's desire to address this problem in a meaningful way. However, we must be certain that the President's proposal does not create unintended consequences. This hearing will allow all of the Members of the Committee an opportunity to explore, in detail, the cost containment proposals in the President's plan."

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit written comments for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

H.R. 3600, the Health Security Act, includes a variety of provisions that would slow the rate of growth in health spending to the rate of inflation by the year 1999.

The bill would establish a National Health Board. This Board would set a baseline amount of health spending and a limit on the annual growth in spending. In the first year, growth in spending would be limited to the growth in the Consumer Price Index (CPI) plus 1.5 percentage points. The limit in the growth in spending would phase down to the CPI by the year 1999.

The Board would allocate spending to each regional and corporate alliance, based on existing variations in spending between geographic areas. The limit on spending in each area would be in the form of a "per capita premium" for services covered under the plan.

Each year, health plans would submit premium bids to each alliance established by the Board. If the average premium was over the target assigned to the alliance, plans with premium bids above the target would be required to reduce their bids such that the average premium in the alliance was no greater than the target. Plans whose premiums are reduced would be authorized to make a proportional reduction in the payments they make to providers.

Witnesses at the hearing will address the following questions:

1. Are the budget limits set in the Health Security Act appropriate, consistent with maintaining quality of care while expanding access to health services?

2. Is the declining rate of growth in health spending realistic?

3. Would effective incentives be created to encourage health plans to control costs?

4. What are the possible unintended consequences of this approach to controlling costs?

5. What will be the impact on insurers, providers, and patients?

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Wednesday, January 5, 1994, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

* * * * *

Chairman ROSTENKOWSKI. Will our guests please find seats? The committee will come to order.

Today the committee continues its hearings on the President's health care reform plan, H.R. 3600, the Health Security Act, with a detailed examination of the cost-containment proposals.

We all agree on the need to contain the spiraling growth in health care costs. Where we differ is in how and how fast. The President suggests a bold and comprehensive plan. It includes significant proposals for slowing growth in health spending and in both the public and the private sectors. The Health Security Act would establish a national health budget and would limit the rate of growth in health care premiums to a predetermined rate.

It seems to me that in considering the cost containment elements of the President's plan, we must answer three basic questions: First, is it possible, both technically and politically, to set and enforce a national budget for health care? Second, are the proposed restraints on the growth and costs reasonable and achievable? Third, will the proposed method of enforcing the budget, based on caps on the growth in insurance premiums, achieve the desired objective? Will this system actually enforce insurers to compete based on cost effectiveness and efficiency?

Those are the principles that I wish our panels would address.

The Chair would like to turn now to Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

I think this is a terrific opportunity for the committee to begin to make a more detailed examination of the cost containment proposals in the President's plan. The need for controlling growth and health care costs is well-known and doesn't need to be repeated today. I am in agreement with the President on many aspects of his cost containment proposals. I strongly support his commitment to establish and enforce an overall national budget for health care.

Yesterday Dr. Reinhardt correctly described our health care financing system as unconnected from normal economic constraints. Until we turn off the flow of funds, the health care system will not begin to make the changes necessary to achieve cost containment. As long as we provide an endless supply of funds, it will be impossible to eliminate waste and abuse in the delivery of health care.

I do have some concerns about the President's plan for controlling costs. Its objectives may be overly optimistic—and particularly in the initial years. I am concerned that the plan uses a different cost containment strategy for private insurers than that used for Medicare. That could provide the inevitable gaming that we are so used to in the Tax Code. I also doubt whether the Health Security Act could create fair competition among insurers as a means to control costs.

Creating a level playing field will require the use of untested processes, particularly risk adjustment. No such adjustment process exists today. In fact, HCFA has been trying to develop that adjustment process for 10 years and has been unable thus far to do it.

Despite these concerns, I think the President's plan gives us a workable starting point. It will have to be modified and perfected. I think this committee can do it. I appreciate your calling these witnesses to advise us as we begin that journey. Thank you.

Chairman ROSTENKOWSKI. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

I join you in welcoming our distinguished witnesses this morning. I am pleased that we are having this hearing to focus on the cost containment aspects of health care because yesterday, I believe, was one of the most informative hearings that we have had on the issue of health care reform.

The economics of health care reform are very complex, and it was pretty obvious from the testimony that the President's plan, as written, will likely have some severe and clearly unintended consequences. Yesterday, all our panelists agreed that the costs of the plan's employer mandate will be borne by the worker, either through reduced wages or lost jobs.

We need to be careful as we reform the health care sector for it impacts every other sector, as was pointed out: Transportation, capital and consumer goods, and service industries. Among potential losers are not simply the nonhealth sectors, but those who would benefit from other government efforts in spending related to education, training, youth development and crime prevention.

Ironically, these efforts include those designed to help people break the poverty-welfare cycle. Poverty and crime are often viewed as principal contributing factors to much of the pathology that our health care delivery system is asked to treat. As we devote increasing resources to health care services, we are taking money away from programs designed to address the underlying causes of the problem. A government commitment to increase real spending on health by hundreds of billions of dollars must inevitably inhibit all over government actions.

We also learned yesterday that the Clinton numbers probably won't work for a variety of reasons, that the costs are likely to be higher than anticipated, that firms and individuals will attempt to maximize their subsidies and that these efforts are likely to be in conflict. We need to be cautious in our examination of baseline budget issues, as was pointed out, and assumptions related to the gossamer-like financing structure.

We need to face the reality that we may not be able to estimate the amount of money that health care reform proposals are likely to cost. We simply don't know enough to predict the human behavior changes that reform will bring. We do not know what the Federal Government is about to purchase, and we don't know how much that purchase is going to cost.

In light of what we heard yesterday, Mr. Chairman, concerning serious doubts about the assumptions surrounding the effectiveness of global budgets and our inability to reduce benefits or otherwise explicitly ration health care, I welcome our panelists' discussion today on cost containment. I hope to hear their thoughts not only on how we can contain costs in today's environment but also to hear discussion about the likelihood of our containing costs in the future once this plan is enacted.

It seems to me that we have the potential for probable health care cost explosion, Mr. Chairman, because, if I understood the panelists yesterday, the Federal Government is assuming most of the financial risk under the President's plan. I look forward to the testimony on cost containment.

Chairman ROSTENKOWSKI. I would like to welcome all of our witnesses today, and I hope that they will be very specific in their comments about what does and what does not work in the President's plan. If there are any problems, it will be up to this committee to fix them, and we will appreciate their assistance in this effort.

Our first witnesses today are Dr. Stuart Altman, chairman of the Prospective Payment Assessment Commission, and Dr. John Eisenberg, chairman of the Physician Payment Review Commission.

Welcome, gentlemen. It is nice to have you with us.

As I told you, Dr. Altman, maybe if we listened to you a little while ago we wouldn't have this dilemma today. You may begin, Dr. Altman.

STATEMENT OF STUART H. ALTMAN, PH.D., CHAIRMAN, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, ACCOMPANIED BY DONALD YOUNG, M.D., EXECUTIVE DIRECTOR

Mr. ALTMAN. Thank you, Mr. Chairman.

First, if you would permit me, I would like to indicate that 10 years ago this month we began working for your committee as the Prospective Payment Assessment Commission, and it is really fitting that we come before you on our 10th anniversary. I particularly would like to thank Chairman Stark for having given us the opportunity over these 10 years to work closely with your committee.

I would also like to introduce again someone who you know well, Dr. Donald Young, who has been with the Prospective Payment Assessment Commission since its beginning as its executive director. It is because of the quality of the staff work under Don Young that most of the good things that we are able to provide you happened. We as the Commission sort of bless it, but the work really takes place under Don.

I appreciate the opportunity, again, of coming before you to talk about this issue. As in the past, I will focus on the potential impact of cost containment under the President's plan on hospitals in particular, leaving to my colleague, Dr. Eisenberg, to talk about how it might impact on physicians and other personnel.

We attempted to look at the President's plan in several ways, mostly by trying to model out what might happen to the various payers for health care should the President's plan be put into effect and what kind of implications those kind of cuts would have on hospitals under different scenarios of how they would behave. Because, after all, as Mr. Thomas pointed out, a lot of behavioral assumptions are built into any plan.

Before I do that, though, I do want to bring to the committee's attention some of the recent economics of what is going on in hospitals. To set the scene, between 1985 and 1992, hospital costs were rising at about 4.6 percent above inflation—so-called real terms. Since the beginning of this year, however, hospital costs have been rising at about half that rate, about 2.7 percent above inflation. And in the last 2 months that we have information, July and August, hospital costs were rising just 1 percent above inflation.

Now how long that could continue, what the implications in the long run might be, we don't know, but we are seeing something rather historic taking place in the hospital industry. Some would say it is a response to the potential of health care reform and what might happen, some say it is finally the realities hitting the hospital industry, that they have to gain control of their costs.

One other piece of information: For the first time in recorded history with respect to the employment cost index, workers that work for hospitals this year received a smaller increase than the average of all civilian workers. Again, we don't want to project out that this will occur forever, but I think it is important, as we think about the future, to realize that hospitals do have the capacity to control costs.

And another thing we talked about yesterday at the meeting is that this is without a major structural change in terms of the availability of beds. We could see down the road a substantial reduction in the amount of excess capacity, which, hopefully, would bring more savings. Again, the issue at stake is can we count on the marketplace, if you will, or is it the potential force of government action that is propelling this? Unfortunately, in past years when we have seen these dips in costs, but as soon as the government and others walked away from it, the costs came back up.

But the question before us all is, is there something fundamentally different happening today? And, as we talked about before Chairman Stark's subcommittee, I do believe we are seeing a fundamental shift. Again, though, the 20 years of being in this town makes me a little skeptical that it will continue forever, but I think you can't ignore it.

With that said, let me take you through what we did with respect to this modeling. If you would be good enough to turn to chart 1 in my testimony, what it shows in that first chart is what exists today or, in our case, 1991. And what it shows is that Medicare—thanks to the aggressive activities of this committee and the Congress, the DRG system has been effective in holding Medicare payments down such that in 1991 Medicare paid about 88 percent of hospital costs of treating Medicare patients.

Now hospitals feel they are underpaid. Some of us in Washington think they are appropriately paid. Of course, that is an ongoing debate. But look what has happened to the other payers. To make up for that 88 percent and the fact that Medicaid and the uninsured are paying about 66 percent, the average private payer of hospital care is paying about 130 percent of their costs. In other words, they are paying an extra 30 percent to make up for the shortfalls.

And when you add it all together, hospitals are doing OK on average. In 1991, their profit margins or operating—they don't like to talk about profit margins; they talk about operating margins—were about 4.3 percent, and, interestingly, the latest figures suggest operating margins are actually increasing for hospitals. So that during this tight payment period, things are actually a little better.

Now, what would happen in the year 2000 if the President's plan were to completely go into effect as envisioned? There has been a lot of talk about the terrible impact of the Medicare/Medicaid cuts on hospitals. Interesting, the Medicare/Medicaid cuts proposed by

the President are actually less of a force than the potential impact of the premium controls.

If you look at the second set of bars in that first chart, you notice that Medicare actually becomes a relatively better payer if hospitals control their costs at the 2.7 percent rate, which they are now doing over the last 9 months. As I will show you in a later chart, if they don't, and they go back to their old ways of 4.6 percent annual cost increases, then Medicare becomes a worse payer, as does everybody else.

But let me focus on this one for another minute. Look what happens to private payers and to the other payers. First of all, under the President's plan, Medicaid would be folded into the private, and there would be no uncompensated care for the uninsured. So those would level out. And, on average, we estimate that they would pay about 97 percent of the costs to stay within the premium caps as proposed in the President's plan.

Now, in modeling this, we were not able to make assumptions about major structural changes any further in hospital care, other than what is already projected. It is not that we took a static model, but we didn't assume a deterioration in the use of hospitals beyond that which has already happened. If that were to happen, these numbers actually would be worse for hospitals.

So when you add it all together, what you find, if you look at the third chart—I am sorry, the third and fourth charts—is that if hospital costs are maintained at that 2.7 percent, as chart 4 indicates, hospital margins would fall from a plus 4.3 to a minus 1.1. If hospital cost increases were to go back to the level of 1985 to 1992, hospital margins, this is for all of their revenues, would fall to almost 10 percent negative, from a plus 4.3.

The next question we asked is, well, what would hospitals have to do to maintain their margins? And what we found is that hospital costs would have to grow by about 1.6 percent above inflation, which is a tough reduction but not an impossible one. So the numbers in the President's plan, while tough, are not totally out of whack in terms of the potential. Hospitals would still be able to generate cost increases above GDP growth.

So the first lesson I want to bring before you is that within the President's plan the Medicare cuts are not nearly as tough as the potential of the premium cuts and actually are less tough if hospitals reduced their rate of growth in costs. Second is that the premium constraints, if they were to be applied across the board, would leave hospitals with either losing about 1 percent or losing about 10 percent, depending on how well they can control their costs.

We next turn to another issue and that is suppose we don't have premium caps? After all, a number of the other plans before you say premium caps are not a good thing, and we should leave them alone. But there is real pressure to continue to cut Medicare.

Suppose you were to cut Medicare the way the President's plan proposed, and you were to leave the private sector alone? What would happen? Well, it depends on how much faith you have in how tough the marketplace is going to be. Now, I am an economist, and, therefore, I am capable of at least saying things about what

is going to happen. The truth of the matter is we don't know. We don't know.

So what we modeled is one of two assumptions. One is that hospitals say, look, we are going to maintain our profit margins; and, two, we are going to maintain our cost structure as exists, say, today, a 2.7 percent annual increase. If they do that, they are going to push the private sector to maintain the same level of cost shifting that exists today, which is about 30 percent above costs. If they go back to the cost structure of the previous 7 years, cost shifting on the part of the private sector would be pushed up to about 137 percent, which, by the way, translates into an extra $60 billion that would be paid for by the private sector.

So what I say to my friends in the private sector who are so convinced the marketplace is going to work fine, I said, you are taking on the potential of a $60 billion gamble. And I am not saying you will not succeed, but you should understand that if you have the Medicare cuts, which are likely to come down the line to keep Medicare in line, and you do not have any safeguards in a budget restriction, you are going to face a tougher environment tomorrow than you face today. That doesn't mean you can't pull it off, but we are just trying to give you the orders of magnitude of what these numbers might look like.

In my testimony I then turn to the issue of the premium caps and what was needed to make them work. First, there is a theoretical justification for premium caps. We talked about it in Chairman Stark's subcommittee. And that is it gives health plans, the delivery system, more flexibility than tighter, restricted budgets.

I personally have looked to a large extent at what is going on in Germany and in Canada and in other European countries. They have what are called sector-specific budgets. In other words, there is a hospital budget, there is a physician budget, there is an outpatient budget, there is often a drug budget.

Two things I would say about them. One, they have worked to the extent that they have held costs down. But, two, they have a much more rigid system than we do. They just do not have the flexibility that our system has.

Now some would say our system is a little too chaotic, but there are a lot of interesting activities going on in the health sector, and, if you don't believe it, go to southern California or Minnesota or, surprisingly enough, Boston, where some interesting things are happening.

So sector-specific budgets restrict the ability of transferring money. Premium controls give flexibility.

On the other hand, no country in the world has ever tried premium controls, and there is the real possibility if you put real tight premium controls and the plans can't meet them, what they are going to do is either give up the ship or turn it over to the government and say, hey, we can't do it. You do it.

And so, yes, theoretically premium controls do have more flexibility, and I personally support them over—over sector specific budgets. But I have to acknowledge we have no experience with them. Nor does any other country.

And, third, as we pointed out in our testimony, you need information, statistically very sophisticated information, to make it

work right, that we just don't have now. That doesn't mean you shouldn't do it, but let me urge you, should you do it, push hard to get that information quickly.

Finally, we have been working on the issue of State-specific spending. Again, States vary substantially in how they spend health care dollars today. Per capita spending varies all over the map.

The question before you, before the President, before this new health board, is do you maintain that differential State spending of today, which, after all, has been going on for a long time and may have some very important historical reasons or do you recognize that this is a country that ought to be spending per capita, say adjusted for age and sex and health status, the same across the country? If you do that, it would mean major redistributions of dollars. And, again, we just do not have the information today to do that.

Again, in my view, it is not a reason not to do it, but it is a reason to generate the information before you do it.

So, in summary, the President's plan calls for tough but not really impossible spending limits. We do not know the implications, though, on the health system of those numbers, but what is interesting is that the current cost structure, if we were to project out the 2.7 percent and get it a little lower, would not be that much out of line from where the President's plan is. So, yes, it is a tough set of limits, but there is the potential out there for us to meet them, at least with respect to the hospital sector.

Thank you, Mr. Chairman.

Chairman ROSTENKOWSKI. Thank you, Dr. Altman.

[The prepared statement and attachments follow:]

TESTIMONY

Stuart H. Altman, Ph.D.
Chairman
Prospective Payment Assessment Commission

Good Morning, Mr. Chairman. I am Stuart Altman, Chairman of the Prospective Payment Assessment Commission (ProPAC). I am accompanied this morning by Donald Young, M.D., Executive Director of ProPAC. I am pleased to be here to discuss the cost containment provisions in HR 3600, President Clinton's health care reform proposal. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

As you know, Mr. Chairman, the President's proposal is a comprehensive program that would provide universal health care as well as fundamentally change the way health care is financed in this country. Most persons under age 65, including Medicaid recipients and those without health insurance, would obtain health insurance coverage through regional or corporate alliances that would negotiate with health plans to provide medical services. Under this proposal, the escalation of health care costs would be constrained by market forces, as health plans compete for patients on the basis of quality and price.

The cost-containment "backstop" in the President's plan is a provision to limit national health spending by capping the growth in private insurance premiums offered through the alliances. Under the proposal, a National Health Board would establish a national per capita baseline premium target based on per capita health care expenditures for a comprehensive benefits package; this target would be updated annually. The national target would then be allocated to the regional alliances on the basis of population characteristics and other factors. The alliances, in turn, would negotiate premium amounts with each health plan in their area based on this target.

Medicare would be retained as a separate program under the President's plan, although it would be subject to a number of cost-saving measures. These measures seek to reduce the growth in Medicare spending for currently covered services by an estimated $124 billion over a six-year period. Some of the savings from these initiatives would fund a new prescription drug benefit for Medicare beneficiaries.

Mr. Chairman, because it involves fundamental changes in the financing of health care services in this country, the President's plan, by its very nature, would have important consequences for hospitals and other health care providers, as well as the patients they serve. Establishing a national baseline target for private health expenditures and allocating that target to states or regions requires a complex set of decisions. These decisions, along with the Medicare cost savings provisions, would have a substantial impact on the distribution of available funds to health care providers. I would like to discuss several of these issues in a bit more detail.

HOSPITAL PAYMENTS, COSTS, AND HEALTH CARE REFORM

Under the President's plan, the annual growth in private insurance premiums would be limited to a national inflation factor based on the Consumer Price Index (CPI). For 1996, premium increases would be limited to the percentage increase in CPI plus 1.5 percentage points. The allowable increases above CPI would be reduced over subsequent years; for the years 1999 and 2000, premium growth would equal CPI growth. For the year 2001 and beyond, the average per capita premium would be allowed to grow at the rate of the increase in CPI plus the rise in real per capita gross domestic product (GDP), unless Congress approves another rate.

Mr. Chairman, the impact of the President's plan on hospitals and other facilities will depend on the ability of these providers to control their costs in response to the decreased rate of growth in payments that is likely to occur. Historically, hospitals have been able to avoid the pressure of payment constraints by some payers because they were able to recoup these costs from other payers; a phenomenon known as cost-shifting. This is best illustrated by the Medicare program. While the Medicare program has been very successful in slowing spending growth, this reduced growth was not matched by reduced growth in hospitals' Medicare and total costs. Despite this gap between costs and payments, the hospital industry has been able to maintain its financial position. This is because rather than reducing costs as Medicare payments were limited, hospitals charged private payers more than the

costs of their care, thus allowing Medicare patients to receive services at costs that could not be sustained by the growth in Medicare payments alone.

The result of cost shifting is that the Federal government has been very successful in controlling Medicare payments with no adverse impact on quality of and access to Medicare services, or on hospitals' overall financial status. This success has come, however, at the expense of increased prices for the subscribers of private insurance plans. In 1991, Medicare payments were $10 billion below what hospitals spent to treat Medicare patients. In addition, hospitals sustained losses of $5 billion from caring for Medicaid patients and $11 billion from the costs of treating uninsured individuals. In aggregate, hospitals were able to cover these losses because hospital revenue from private payers exceeded costs by $26 billion.

In addition to its impact on private payers, cost shifting places hospitals that provide services to a disproportionate share of Medicare and Medicaid beneficiaries and charity care patients at a disadvantage compared to other hospitals. It also puts greater pressure on those hospitals in areas where private payers control their payments to hospitals. Thus, as a result of cost shifting, hospital financial condition is increasingly being determined by payer mix, rather than production efficiency. As costs continue to rise, growing public payer and uncompensated care losses cannot be covered by an increasingly cost-conscious private sector.

The President's plan to provide universal health care coverage and limit what private health plans can charge in premiums would impose strong incentives for hospitals to reduce their costs, as well as reduce cost shifting by curtailing hospitals' ability to raise revenues from private payers.

Recent evidence suggests that hospitals may have started to constrain the rate of increase in their costs. This could be occurring because hospitals are anticipating health care reform or because increasing financial pressures from private payers have lessened their ability to generate additional revenue. After peaking at 5.0 percent in 1992, annualized real growth (above inflation) in hospital costs per case dropped to 2.3 percent for the first eight months of 1993; whether this is a one-time phenomenon or the beginning of a trend is unclear.

I would like to emphasize, Mr. Chairman, that in evaluating the President's proposal, it is important to remember that spending constraints in the private sector are intended to accompany the additional payment constraints under Medicare, most notably the reduction in PPS payment updates. Interestingly, most public attention to the President's cost containment plan has focused on Medicare cuts in spending, yet the PPS update factor, together with changes in the case-mix index, are likely to result in increases in per case Medicare hospital payments that are somewhat higher than those received from private payers. These effects are reflected in the relative payment to cost ratios for Medicare and private patients, as seen in Chart 1. If hospitals continued to contain their costs at the 1993 rate, Medicare's combined inpatient and outpatient payments, relative to costs, would increase from 88.4 percent in 1991 to 91.7 percent in 2000, while payments from private payers, relative to costs, would fall from 129.7 percent in 1991. Because under health reform there would be no distinction from the provider's point of view between patients who are currently privately insured and any other patient who is insured through the alliance, the payment to cost ratio in 2000 for all non-Medicare patients would be 97.5 percent.

It is important to note that this analysis is based on a number of assumptions about trends in health care provision and payment, including that the health plans will allocate their premiums across providers consistent with the currently projected distribution of health care spending. This assumption may not hold up over time because spending for hospital outpatient, home health, and nursing facility services is growing more rapidly than inpatient hospital spending. The rapid increase in the volume of services provided is the major reason for this spending growth. If patients continue to receive more of these services at current rates, prices per unit would have to be severely constrained to meet the President's spending limits. If prices paid are not reduced sufficiently and the growth in non-hospital services continues, the health

plans would be forced to allocate an increasing share of their premiums to these alternative services and, therefore, reduce still further what they pay for hospital care.

A premium approach has the appeal of allowing the health plans to determine the spending growth for each sector--by controlling both price and volume. One result of this could be that payment growth for inpatient hospital care would be constrained below the level of the cap to allow spending in other sectors to increase more rapidly. If hospital revenues were reduced, but admissions were not, revenue growth would drop substantially below the current cost growth and hospital margins would be much lower.

I should point out, Mr. Chairman, that while premium caps provide an incentive for health plans to constrain service volume in these non-inpatient settings, the Medicare payments to facilities generally do not incorporate similar incentives, particularly for hospital outpatient and home health services, both of which have shown substantial volume growth. While the Medicare provisions of the President's plan would reduce the growth in per service payments in these sectors, actual spending will likely continue to rise due to accelerating volume. The Medicare program may need to develop ways to control this rapidly growing volume.

POSSIBLE IMPACT OF PAYMENT CONSTRAINTS

Mr. Chairman, I now would like to focus on the impact of payment constraints on providers. To understand the potential impact of the President's plan, ProPAC analyzed hospital margins under three scenarios of different rates of growth in real (inflation-adjusted) hospital per capita costs from 1993 to 2000, as illustrated in Chart 2:

- continuing at the average real rate from the most recent seven-year period--4.3 percent a year;
- continuing at the estimated real rate of growth for the first eight months of 1993 projected forward--2.7 percent a year; and
- equal to the real per capita increases in hospital costs necessary to maintain total margins at their current level--1.6 percent per year.

We did not adjust these costs to reflect the shifts in utilization across sites of care that are likely to occur as a result of the President's proposal. Nor did we reflect the potential effects of increased utilization of hospital services by those persons currently uninsured.

The analysis of the possible effects on total hospital margins is based on data from the American Hospital Association on hospital payments and costs by payers in 1991, inflated to 1995 using the Congressional Budget Office's most recent projections of spending for hospital services and Medicare's hospital spending estimates. These estimates are then trended forward to 2000 reflecting the limits on private sector premium increases and Medicare spending reductions proposed by the President. We also assumed Medicaid payments at 95 percent of the amount of Medicaid spending in the base year. We did not include any adjustments for the reductions in Medicaid disproportionate share (DSH) payments proposed by the President because our base payments were from 1991, before the large jump in these payments. We also included a conservative estimate for the additional revenues hospitals would receive from covering uninsured persons by assuming that utilization for this population would continue to increase at the current trend.

Our first analysis assumed that per capita hospital costs would grow at the same rate they were growing between 1985 and 1992, that is at 4.3 percent per year above inflation, or a total of 8.3 percent annually between 1995 and 2000. The second analysis assumed that hospitals could keep their cost growth constrained to the 1993 level, that is about 2.7 percent per capita above inflation, which would result in a 6.7 percent total annual rate between 1995 and 2000.

As you can see in Chart 3, if costs continued to rise at the average per capita rate experienced between 1985 and 1992, hospitals' total margin would decline to -9.0 percent as the President's proposal was phased-in. Chart 4 uses the same revenue assumptions but assumes that hospitals could keep their cost growth constrained to the 1993 level, that is about 2.7 percent per year above inflation. Under this scenario, the hospital total margin would fall to −1.0 percent in 2000, sharply lower than the 4.3 percent level in 1991.

To maintain their current total margin of 4.3 percent, hospitals would have to hold their real per capita cost growth to 1.6 percent a year, or a total annual increase of about 5.5 percent. Rates of this magnitude have been achieved only temporarily during the voluntary cost constraints of the late 1970s and the first year of Medicare's PPS.

As I noted earlier, Mr. Chairman, the cost containment "backstop" in the President's proposal is a cap on the growth in private insurance premiums. There has been much debate about this aspect of the proposal, and an alternative approach that has been discussed is to rely upon market forces to control private spending, while cutting the growth in payments from public programs. To better understand the impact of such an alternative approach, ProPAC examined the possible effects of a plan that would constrain Medicare spending as the President has proposed and limit Medicaid payments to the 1991 payment to cost ratio of 81.6 percent. This analysis did not include a private payer premium cap, and excess payments from private insurers are assumed to continue to provide the bulk of funding for hospital services used by the uninsured.

The effect of this approach would be to increase pressure for hospitals either to reduce costs or to obtain additional payment through cost shifting. Charts 5 and 6 indicate the payment to cost ratios for private payers that would be necessary by the year 2000 to maintain hospitals' total margin at its current 4.3 percent level, if spending by government programs and for the currently uninsured were controlled as I have just described. If the 1993 rate of 2.7 percent real per capita cost growth were sustained, hospitals would require payments of 29.2 percent above costs from private payers--about the same as the 29.7 percent that they received in 1991, but much higher than the level with a private payer premium cap. If, however, hospital cost growth resumed at the 4.3 percent real per capita rate observed between 1985 and 1992, hospitals would require private payer payments 37.3 percent above costs--an excess of more than $60 billion. Such an approach would reduce the pressure for cost containment, increase the financial burden for employers and employees, and cause severe financial distress for hospitals with limited ability to cost shift.

These findings dramatically demonstrate, Mr. Chairman, that the critical factor in determining hospital financial status under health reform will be how well hospitals can control their cost growth. On the one hand, the cost constraints that will be asked of hospitals have seldom been achieved. On the other hand, they would be able to maintain their total margins at acceptable levels if they hold their cost growth to a rate that would still exceed the growth in the GDP.

While the charts I have presented are only illustrations, Mr. Chairman, it is clear that under the President's plan, health care providers would face stiff incentives to control their production costs. It is anticipated that the increased financial pressure would lead providers to furnish services more efficiently. The proposal's premium limits and Medicare reductions, however, would cause an unprecedented slowing in the growth of provider revenue. The extent of hospitals' ability to slow and maintain cost growth at these levels--and the resulting impact on patient care--is unknown. Further, certain types of hospitals may be more affected by payment restraints than others.

We are moving, Mr. Chairman, into an area in which we have little experience. It is clear that we will need to carefully monitor the effects of these reductions to ensure they are applied in a way that will not unduly affect access and the quality of services furnished to patients. We should recognize up front, however, that reductions in spending of this magnitude will not come about simply by increased efficiency and

reductions in administrative costs. Some loss of services will, no doubt, occur. The question is how important such services really are to quality medical care.

Allocating Premium Targets

Mr. Chairman, I now would like to turn to another cost containment issue that relates to both the equity of the President's plan and quality of care. This is the method the President proposes to allocate premium target limits across geographic areas. Under the President's plan, the national average premium in the first year would be allocated differentially to the regional alliances; the regional alliance premium amounts would be updated annually by region-specific inflation factors. For the initial year, the premium target would be based on the national target and adjusted to take into account state per capita health care spending patterns, premium variations, rates of uninsurance and underinsurance, Medicare program spending variations, and other factors. The ratios would be designed such that the weighted average of all the regional alliance inflation factors would equal the national target; in other words, the allocation would be budget neutral. This provision is intended to ensure that the spending limits are met. Enforcing strict spending limits, however, also increases the need to make sure that the adjustments the President proposes result in appropriate spending distributions across states. Before I discuss this further, I would like to note one other topic that is critically important.

Each alliance is expected to negotiate with health plans to determine the premium amounts that comply, in the aggregate, with the alliance target. Since individual health plans are likely to enroll different mixes of patients--in terms of social, economic, and health status characteristics--it is critical that the health plan payments be adjusted to reflect each plan's mix of subscribers. The President's proposal calls for such an adjustment, but the current state of knowledge in this area is limited and must be strengthened if payments are to be adjusted appropriately.

I would now like to return to the geographic allocation of premium targets. There is substantial variation in spending patterns across states; this variation is magnified at the sub-state level. The problem is that relatively little work has been done to calculate and understand the reasons for geographic variation in health spending. The Federal government last published state estimates on health care spending in 1982. The Health Care Financing Administration is in the process of calculating state level spending estimates for personal health care services for the year 1991. ProPAC currently is conducting an analysis of variation across states, as well as urban and rural areas, in health care spending and costs for the aged Medicare population. We hope this information will be useful in understanding the variation in health care spending.

There are tremendous differences across this country, Mr. Chairman, in terms of both the per capita utilization patterns of health care services and the health care systems that provide these services. In our recent June Report to Congress, we described the range of these differences at the state level, looking at population characteristics such as wealth, age and health status, and characteristics of the health care system, such as the supply of health care services, and policy and regulatory environments. Each of these factors affects the level of health care spending; however, we are still in the process of attempting to understand the relationship between these factors and spending patterns.

Absent an understanding of the reasons for geographic differences in spending patterns, a fundamental policy question, Mr. Chairman, is whether to allocate the premium targets based on historical spending patterns--thereby locking in current spending differentials across areas--or to impose adjusted national spending averages on all areas. Either allocation option would have a significant impact on the distribution of spending and the resources available to furnish medical services in each geographic area. We must carefully monitor the effects of geographic allocations on different population groups. An important component of this analysis will need to be a better understanding of why and how different population groups use different types and amounts of services. This information also can be very helpful in developing "risk

adjustments" for health plan premiums for these different groups. Appropriate allocation decisions and adjustments become even more important in light of the very tight limits on spending increases that the President has proposed.

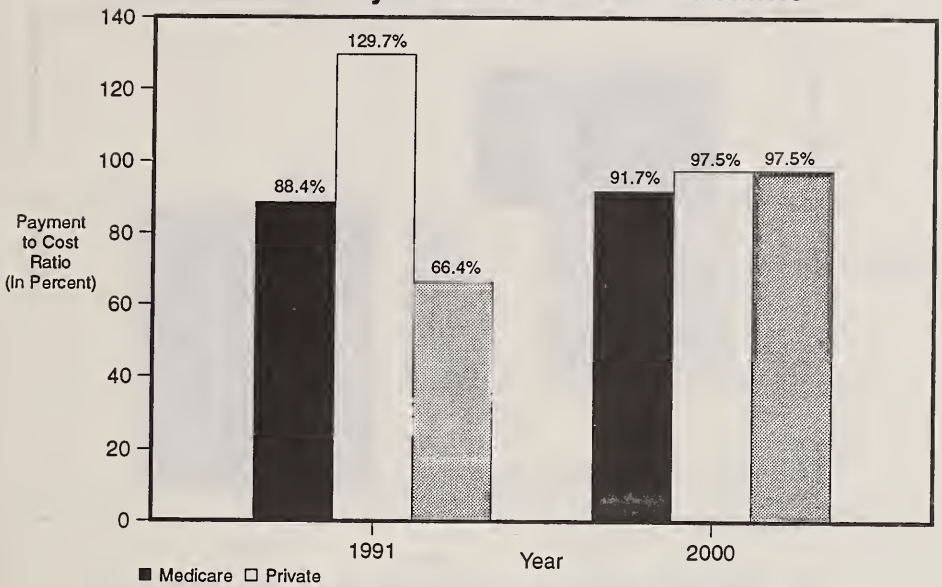
CONCLUSION

The President's proposal to cover the uninsured, limit spending increases in the private sector, and slow Medicare and Medicaid spending growth will interact in ways that are difficult to predict. The plan would greatly slow the rate of increase in provider payments and curtail the ability of providers to raise revenues from some payers to cover losses from others. It is anticipated that the increased financial pressure will lead providers to furnish services more efficiently. The proposal's premium limits and Medicare reductions, however, would lead to an unprecedented slowing in the growth of provider revenue. We need to carefully monitor the effects of these reductions to ensure they are applied in a way that will not unduly affect access and the quality of services furnished to patients.

Mr. Chairman, any approach to health care reform that successfully controls the growth in health care spending and provides health care coverage for the uninsured population will have a substantial impact on hospitals and other providers of health care services. Under the President's proposal, we should expect substantial changes in the way health care services are delivered. The proposal could lead to large redistributions in payments across geographic areas and among types of providers. Many of the effects of the proposal will be determined by important technical details and the responses of plans and providers. The allocation of premiums to the health plans and the ability of the plans to furnish necessary and appropriate services for the premium amount are critical elements of the proposal. ProPAC will be pleased to continue working with this Committee and the Congress as you seek to implement solutions to the problems facing America's health care system.

I would be pleased to answer any questions you or other members of the Committee may have.

Chart 1. Hospital Payment to Cost Ratios for Medicare and Other Payers with Payment and Cost Constraints



Note: 1996-2000 payment increases modeled to reflect Clinton Administration proposal; per capita cost growth assumed at 2.7 percent above inflation.

Chart 2. Alternative Growth Paths for Hospital Real Per Capita Cost, 1985-2000

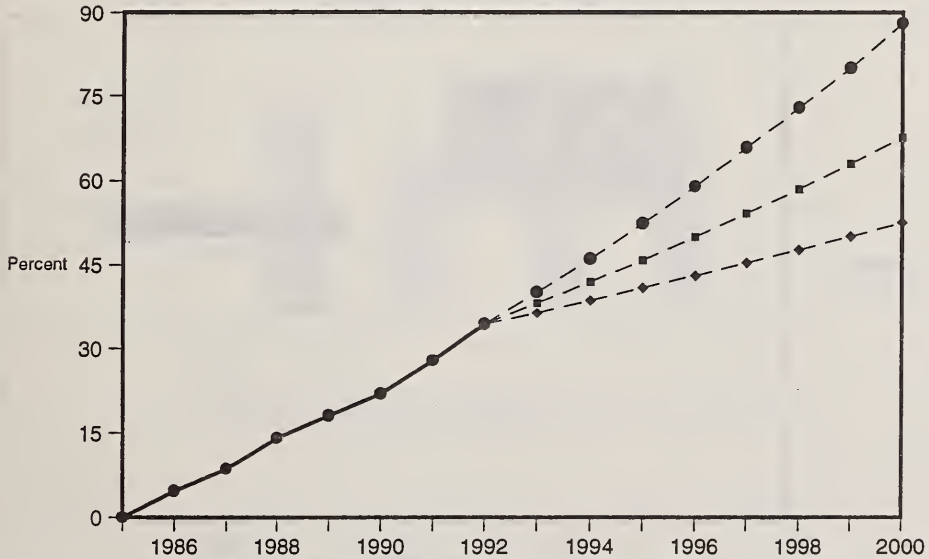
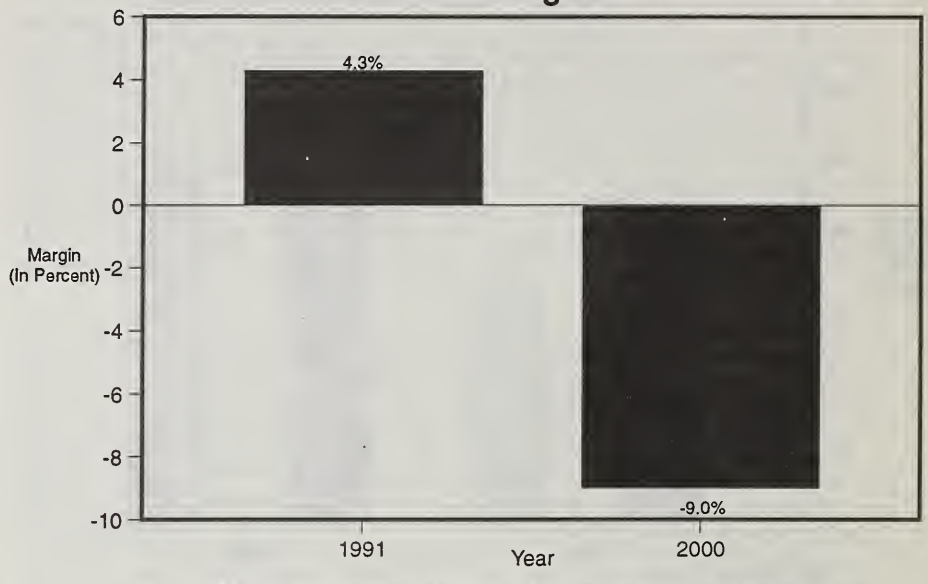
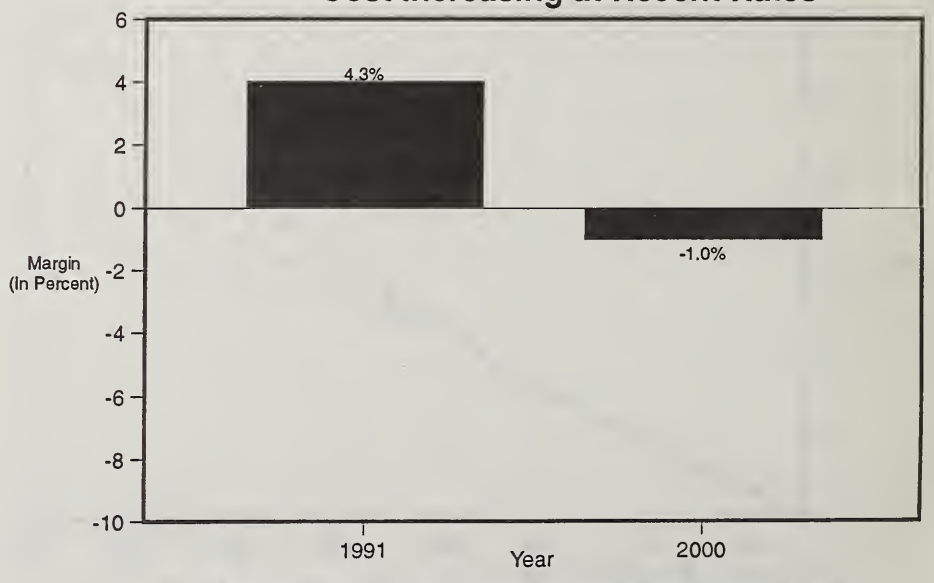


Chart 3. Hospital Total Revenue Margins with Constraints on Payment Growth and Cost Increasing at Historical Rates



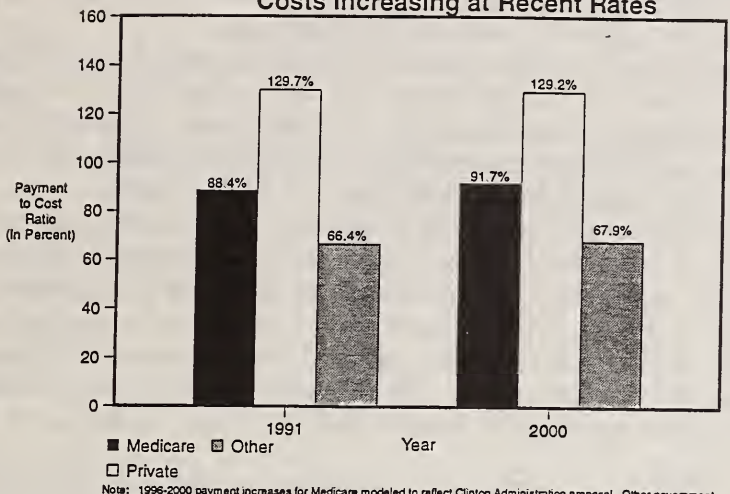
Note: 1996-2000 payment increases modeled to reflect Clinton Administration proposal; per capita cost growth assumed at 4.3 percent above inflation.

Chart 4. Hospital Total Revenue Margins with Constraints on Payment Growth and Cost Increasing at Recent Rates



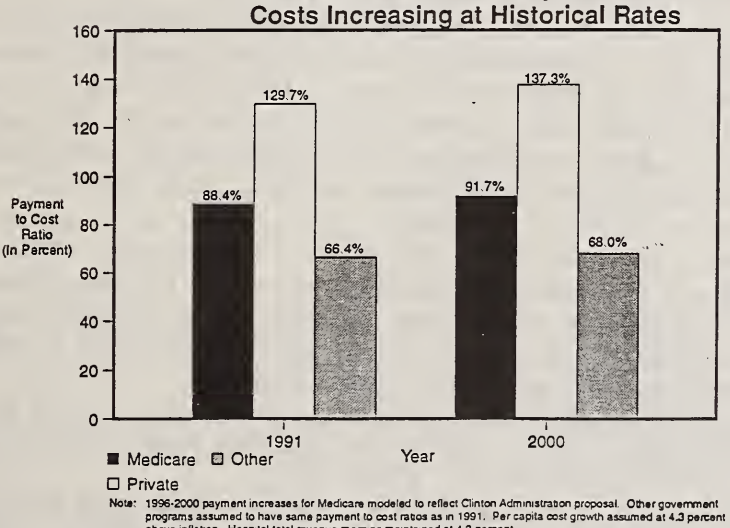
Note: 1996-2000 payment increases modeled to reflect Clinton Administration proposal; per capita cost growth assumed at 2.7 percent above inflation.

Chart 5. Private Payment to Cost Ratio Required by Hospitals to Offset Constraints on Other Payments with Costs Increasing at Recent Rates



Note: 1996-2000 payment increases for Medicare modeled to reflect Clinton Administration proposal. Other government programs assumed to have same payment to cost ratios as in 1991. Per capita cost growth assumed at 2.7 percent above inflation. Hospital total revenue margins maintained at 4.3 percent.

Chart 6. Private Payment to Cost Ratio Required by Hospitals to Offset Constraints on Other Payments with Costs Increasing at Historical Rates



Note: 1996-2000 payment increases for Medicare modeled to reflect Clinton Administration proposal. Other government programs assumed to have same payment to cost ratios as in 1991. Per capita cost growth assumed at 4.3 percent above inflation. Hospital total revenue margins maintained at 4.3 percent.

Chairman ROSTENKOWSKI. Dr. Eisenberg.

STATEMENT OF JOHN M. EISENBERG, M.D., CHAIRMAN, PHYSICIAN PAYMENT REVIEW COMMISSION, ACCOMPANIED BY PAUL B. GINSBURG, PH.D., EXECUTIVE DIRECTOR

Dr. EISENBERG. Thank you, Mr. Chairman.

As you mentioned, I am John Eisenberg, and I chair the Physician Payment Review Commission. In my other role I am chairman of the department of medicine at Georgetown University Medical Center here in Washington, and I am accompanied by Paul Ginsburg, who is the executive director of the Commission.

We would like to address six different themes in our comments. The first has to do with the goals for cost containment. Second, how we might achieve those goals. The third is the States and the alliances, the way in which they might contribute to that achievement. Fourth, fees and how they might be adjusted. Fifth, competitive markets. And then, sixth, whether there are some complementary policies that might be instituted to help us achieve cost containment.

Now, the PPRC is currently analyzing a variety of these issues, and we are pleased to indicate to you today those areas where we have either leanings or conclusions or to tell you what we are analyzing. But I assure you we will be in close communication with the committee and with Congressman Stark and the other members of the subcommittee through memoranda, hearings, as well as our report which is scheduled to come out in March.

Now, on the first issue, the goals for cost containment, the Commission has been considering two basic approaches that are possible for short-term cost containment, fast and slow basically. The fast approach says, let's have a quick decline in the rate of increase, so that we can obtain the savings which are necessary for the other elements in health care reform. And then if we need to come back up over time, we can.

The second approach is to say that, well, maybe what we ought to do is to have a more gradual decline over a longer period of time, recognizing this approach may place some constraints on the money that might be available for all of the elements of reform.

[The following was subsequently received:]

In addition, the Commission is seeking to determine what type of growth rate is desirable in the long term—whether health spending should grow more slowly or more quickly than the gross domestic product (GDP).

Now as we look at those options we are informed by the experience that we have had with the Medicare volume performance standard. As has been our position on this issue in the past, we believe that if the number of beneficiaries is considered, if the inflation rate is considered, that, basically, a national rate of growth could be keyed to or targeted to the national rate of income growth per capita.

We are exploring a goal, though, at this point which might key long-term spending growth to this adjusted GDP per capita, plus some additional amount which might enable the country to either increase access or to increase technology. The reason that we are considering this additional amount—for example, it might be 1 percent—is because, as we look at other countries, we observe that it

has been very difficult for other countries to contain their costs at a lower level.

Second, there seems to be a relationship between the wealth of a Nation, its gross domestic product, and the proportion of the gross domestic product that it spends on health care. And, therefore, it might be appropriate that we—as a wealthier Nation—spend somewhat more than the rate of increase in the gross domestic product.

However, as we look at the expenditures for health care over the past 30 years, we conclude that they are too high, and we definitely need to see a reduction in the rate of increase. The question then is whether gross domestic product adjusted for inflation and beneficiary growth, is the right target or whether there should be some additional margin even if it is relatively small.

Now once that number is agreed upon, the question is the second one, which is, how are we going to achieve those cost-containment goals? Our experience in PPRC with regard to the Medicare program has depended very much upon rate setting. And, as we think about rate setting, we believe it does have some promise but that it presents certain problems in managed care plans.

And so we turn to the option of looking at premium caps or premium limits, and we realize this approach, in fact, is attractive and is favored by many as a way of limiting the rate of increase in a scenario where there is a substantial amount of managed care.

We are concerned, though, that premium caps could lead to some potential inequities, and our concern about those inequities is based upon the limited databases that we currently have to help us to correct for those inequities. The fact that risk adjustment, even as much as it has improved, still leaves us uncertain about the adequacy of the current methods of controlling for risk selection, therefore, the premium caps might put undue pressure on plans that, for one reason or another, have attracted more costly enrollees because of underlying disease or underlying risk of expenditure.

Another issue that we are concerned about with regard to premium caps is the establishment of historic baselines. We could imagine scenarios where plans were effectively locked into their historical baselines, and they might just disband and reform even if it is just under another name in order to become eligible for a new baseline or a new premium cap. And we are concerned that a blind allegiance to the premium caps could lead to that kind of gaming. Our sense then is that we ought to be looking at a policy where we have standby premium limits that might be triggered if the critical goals that we have established for growth in the health care sector are not achieved in the first few years under reform.

But we believe it is absolutely critical that the Congress do everything that it can to assure that the data are capable of providing us with a timely estimate of what that rate of growth is if we are going to have these premium caps that then could be implemented if the rate of growth doesn't stay within the boundaries that have been established.

We recognize, though, that if a mechanism like that—a standby mechanism of premium caps—were instituted, there may be some issues regarding how that would be scored on the budget, and we

would want to work with you to try to deal with those issues as much as we could.

The third issue is, once you have established those rates of growth and you have done what you can to establish either rates or premium limits, is how the States and the alliances would play a role in implementing those limits on increases in expenditures. We have been very interested in the fact that there could be separate historical baselines or separate targets for each State. We recognize that that is very attractive to many.

We do recognize, though, that there are some very serious technical challenges in doing so. And I would like to enumerate some of those. One is an issue that I have already mentioned. That is the availability of the data.

There also are some adjustments that are necessary. For example, we recognize that the current data that we have, especially in the Medicare system, are based on providers, not on the recipient of the care. And there is a substantial amount of border crossing that occurs so that the adjustments would need to take that into account.

Second, there are a number of individuals who would be excluded from the alliance system—Medicare beneficiaries, for example, employees in large corporations—and we have to deal with how we would exclude them from an alliance-based or State-based premium cap or limit on expenditure growth. Another is that cost sharing is off budget, so that if we ended up with the consumer bearing more of the costs out of pocket, and those were not included in the expenditures that were counted within the limit, then we could end up with a system that would simply shift the expenditures from the insurance or public sector to the out-of-pocket costs of the individual, and that really wouldn't accomplish anything for the country as a whole.

We also recognize the fact that if the expenditure limits do exist, that we need to adjust for the increased utilization that is likely to occur with a standard benefits package being offered to all Americans.

When you correct for border crossing and the increased utilization for the uninsured, it turns out that eight States and the District of Columbia would find their targets adjusted by more than 10 percent. So these adjustments really are very, very important.

We also have given you two tables, and I would like to just mention what they demonstrate to you.

[The following was subsequently received:]

EXHIBIT 1
ADJUSTED NATIONAL SPENDING TARGETS, BY STATE
Adjustments for State Differences in Age Distribution and Input Prices

Percent above or below national average	Number of states
20% to 30% below average	2
10% to 20% below average	26
0% to 10% below average	9
0% to 10% above average	9
10% to 20% above average	4

Note. The distribution appears skewed because smaller states generally have adjusted targets below the national average, whereas larger urban states have targets above the average.

Note. Input price adjustments are based on Medicare data.

Source. PPRC preliminary analysis.

EXHIBIT 2
CURRENT STATE SPENDING
RELATIVE TO ADJUSTED NATIONAL TARGETS

Ratio of 1991 adjusted spending to adjusted national target	Number of states
0.75 to 0.85	1
0.85 to 0.95	10
0.95 to 1.05	17
1.05 to 1.15	15
1.15 to 1.25	7

Note. 1991 spending estimates are based on HCFA estimates of state per capita spending, adjusted for border crossing and proportion of uninsured individuals by states. Adjusted national targets are based on 1991 national per capita spending, adjusted for the age distribution and input prices for each state.

Note. Border crossing and input price adjustments are based on Medicare data.

Source. PPRC preliminary analysis.

These tables represented very preliminary analyses that are still being refined. We would be happy to supply the committee with revised tables as our work continues. The results of this work will be published in the Commission's annual report to Congress at the end of March.

Dr. EISENBERG. Basically, the first exhibit which you have is a table which is entitled Adjusted National Spending Targets by State. This answers the question how much would State targets differ from the national target if we were to adjust for State differences in age distribution and in input prices? What you can see is that there are 26 States with targets 10 to 20 percent below the national average, and 2 States with targets 20 to 30 percent below the average.

On the other hand, there are nine States with targets 0 to 10 percent above the national average, and four States who are 10 to 20 percent above average.

Starting from these State targets, it becomes very, very interesting to consider whether States would be in compliance. The second exhibit tells us what would happen if we compared current State spending, adjusted for border crossing and for the increased initialization that would occur if those currently uninsured could obtain coverage.

How would current State spending compare to the adjusted targets in exhibit 1? Data that have been calculated by the staff of the PPRC over the past couple of days demonstrate that 15 States would have a ratio of their adjusted spending to what their target would be of 1.05 to 1.15, and there are 7 States that would be between 1.15 and 1.25. That doesn't even count the District of Columbia, which is somewhere off the map here.

Therefore, we would have about 40 percent of our States whose current spending would be substantially greater, at least 5 percent over what they would have to be spending to meet an adjusted target.

Now that causes us, as it would you, I am sure, great concern because of the amount of variation in the State expenditures, and what that means we would have to do in order to get to the targets quickly. There would be very large dislocations in bringing current spending to the new levels of spending that we would be recommending.

Now, if we do try to get to these limits, whether quickly or slowly, fee schedules is one way of doing so. The Commission has a substantial amount of experience, as do you, with the relative value scale. We believe that a Federal relative value scale ought to be used to provide the basis for fee schedules that are used by private payers around the country, and that the Federal relative value scale ought to start with the Medicare relative value scale.

But we recognize that some changes are needed, and we believe that the Congress should continue to work on modifications like resource-based practice expense payments, refinements of relative values for services not in the Medicare benefit package, and other adjustments about which we have been in discussion with Chairman Stark's subcommittee for some time.

The issue of balance billing will be a very serious one. The Commission has considered this issue, and we recognize that there needs to be a limit on total expenditures and on the out-of-pocket expenditures.

Yet we do also recognize that it would be salutary to have some kind of a safety valve for physicians and patients who believe that the fee schedule may be too restrictive. And we believe, therefore, that some balance billing might be necessary. We want to work with the committee to discuss the corridor that might exist for limiting balance billing. We are not sure that it ought to be exactly what the Medicare corridor is. There are members of our Commission who believe that it ought to be a somewhat higher percentage.

The next issue is the role the competitive markets might play. We recognize the merits of different models of organizing the markets, and we are attracted to many of them. We are not confident yet that the construction of those markets ought to be left to a nongovernmental entity. We believe that governmental entities might be able to make those markets or to assure that those markets exist and to manage some of the regulatory issues that need to be considered.

Now the Commission has also expressed a substantial amount of interest in the idea that where there are metropolitan areas that cross boundaries that those areas might be better treated as one single marketplace, as one single competitive market. Because that is, in fact, the way they are currently operating. And we would like to work with the committee to consider ways in which we might create a single entity that might be responsible to more than one State for those natural marketplaces that exist in adjoining States. That will be a tough issue, but it is one that we think is extremely important.

The final issue that we want to emphasize has to do with complementary policies for cost containment. We believe an expenditure limit, whether it is managed through premium limits or fees or other mechanisms, is very important. But there are other mechanisms that we ought to continue to work together to try to implement. One of the most important on the physician side is the capacity of the physician work force. And we believe that, as we have discussed with the Congress before, that major reform in graduate medical education financing is necessary.

We do come to a different conclusion from the administration, though, in two areas. The administration has suggested that there might be a limit on the number of residents that would be permitted, but it would not be established ahead of time. We believe that it is absolutely critical that there be a limit on the number of residents who are trained. We would be comfortable with a limit being written into legislation but believe that its consideration at least ought to be mandated for the National Health Board or other organization.

We also believe that the specialty goals, which are set in statute in the President's proposal, might be made more flexible, because they might, in fact, change over time. The data would come in on a regular basis and would help us to decide what those specialty mixes ought to be. And we believe that it would be appropriate for a Federal Commission to make those kinds of decisions.

We also believe, in addition to the graduate medical education reforms, that we need serious reform in our national data strategies. We believe that we ought to consider regional data organizations. We ought to be looking at claims clearinghouses as a way of gath-

ering the data that we need for profiling of health plans, profiling of physicians. Much better data are going to be necessary if we are going to move in the long term or the short term to reasonable cost containment.

Next, we believe that we ought to continue to work for outcomes research, technology assessment, practice guidelines, and we would like the Congress to consider seriously an expansion of the technology assessment efforts that are currently underway. The Commission in its last meeting discussed whether or not cost ought to be included in that technology assessment, and the general sense of the Commission is that omission of cost from the assessment of new technology would be a serious mistake.

Finally, we believe medical malpractice reform is a very serious issue and that we ought to go farther than the administration's proposal. We suggest that we move to limits on noneconomic damages, and we have a set of other recommendations that we will be working through, and sharing with you in the near future.

We appreciate the opportunity to come join you today and look forward to our continuing relationships with the committee. Thank you.

Chairman ROSTENKOWSKI. Thank you, Dr. Eisenberg.

[The prepared statement follows:]

STATEMENT BY THE

PHYSICIAN PAYMENT REVIEW COMMISSION

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Chairman

As the Congress considers options for health care reform, the opportunity to expand access and maintain an affordable, high-quality health system depends on designing policies that will result in effective cost containment. The Physician Payment Review Commission strongly supports the need for substantial cost containment because of the effects that rising health costs have on both private and public spending.

In general, the high cost of health care forces individuals and society to pay more than they want for needed health services and reduces their ability to direct resources to other priorities. For some people, these costs have historically made health care unaffordable and denied them access to needed services. For others, rising costs threaten to reduce the access they now have. Successful cost containment, by contrast, will improve the affordability of care and thus the nation's ability to achieve expanded access for vulnerable populations.

In addition, rising costs place stress on federal and state budgets. For the federal government, spending levels influence the budget impact of health system reform. Although reduced premiums for private health insurance have no direct impact on the federal budget, they have at least three indirect effects. First, the federal government will spend less on subsidies to low-income individuals when premiums are lower. If subsidies are set as a percent of income or payroll, then amounts are particularly sensitive to premium levels. Second, the government as employer will spend less on direct payments for federal employees if premiums are lower. Third, reduced private-sector premiums would generate increased federal revenue because individuals and firms or their employees would pay taxes on money saved as a result of lower premiums.

Two approaches to cost containment in health care have emerged over the past few years. One looks to the ability of market pressures to motivate cost containment by organized health plans. The other emphasizes government-set limits on either provider payment rates or plan premiums. The Administration's proposal starts from the first approach by structuring markets so as to achieve savings while also incorporating a system of premium limits and fee schedules to serve as a backup to guarantee that savings are achieved.

The Commission over the past two years has analyzed a variety of issues underlying cost containment. For example, in July the Commission submitted to this Committee a report, *Expenditure Limits: Design and Implementation Issues*, that considered a number of issues that might arise in setting up a global-budgeting system, especially as it relates to physician and other professional health care services. That report focused specifically on the enforcement of expenditure limits through rate setting, the applicability of rate setting to organized systems of care, and the issues involved in assigning the limits to states.

Currently the Commission is analyzing a variety of issues involved in health system reform:

- graduate medical education;
- risk adjustment;
- medical malpractice reform;
- fee schedules for private payers;
- expenditure limits enforced through premium limits;
- access for the underserved;
- quality assurance;
- the structure, roles, and geography of health alliances;
- coverage decisions for new services and technologies;

- regional and national data needs;
- increased managed-care options for Medicare beneficiaries; and
- the Administration's proposed Medicare cuts.

While recommendations have not yet been made, the Commission is happy to share with the Committee our analysis to date of these issues. The Commission will meet in January and February to consider recommendations on these issues and will be communicating them to the Congress on a regular basis through testimony and memoranda, as well as through submission of its annual report at the end of March.

This statement addresses several broad issues relevant to this hearing. Specifically, it considers what goals policymakers might set for expenditure growth and looks at the potential role that expenditure limits might play in achieving these goals. It then analyzes a number of policy and technical issues that arise in assigning expenditure limits to states or substate regions and builds on earlier Commission work to describe the role that fee schedules might play in a reformed system. The statement also describes briefly different ways that competitive markets might be structured under health system reform. Finally, it identifies complementary policies that might make cost-containment goals easier to achieve.

GOALS FOR COST CONTAINMENT

The first question is how to set goals for the growth of health spending. Generally, as reforms take effect, different rates of growth may be desirable over different time frames. Thus, it may be appropriate to delineate different standards for spending growth in the short and long terms, and the Commission is considering recommendations for both.

Specifically, the Commission has been considering whether short-term goals should follow one of two patterns: (1) relatively high short-term goals in the form of a gradual phase-in from current high spending levels to long-term targets that fall below the current levels or (2) relatively low short-term goals that reflect the ability of reforms to produce immediate savings. The Commission is looking for the Administration to put forth in greater detail its case for establishing the credibility of the second option.

Many policymakers agree that the system has the ability to achieve substantial savings in the short term. The Administration's proposal, for example, calls for reforms that might lead to short-term savings that bring the rate of growth of health costs down to the level of inflation over four years. First, administrative savings and reduced marketing costs are anticipated from restructuring the insurance market, for example, because insurers would not need to market individually to small firms. Second, some consumers are expected to move into lower-cost plans as more choices are offered to them with a fixed contribution from their employers. Lower goals might be set in the short term to reflect the potential for purchasers, taxpayers, and consumers to capture these types of savings.

After the first few years, the system may be able to accomplish other short-term savings that require a longer lead time. For example, under the constraints of either rigorous competition or expenditure limits, health plans are given strong incentives to discover better ways to weed out inappropriate care and to move care into more cost-effective settings. Similarly, it is expected that more choices would be offered to consumers as markets mature and as more efficient plans are created around the country.

The Commission is also seeking to determine what type of growth rate is desirable in the long term. In making its annual recommendations for the Medicare Volume Performance Standard, the Commission adopted a goal of reducing expenditure growth in physicians' services to a level that reflects increases in the number of Medicare beneficiaries, inflation, and the national rate of growth in real income per capita. The Commission is exploring a goal that would allow long-term spending to grow at a rate somewhat above the rate of growth in the gross domestic product per capita, for example, one percentage point. Historically, most countries have spent a higher portion of national income on health care as income grows -- allowing room to make new and improved treatments and technologies more accessible to greater numbers of people. The U.S. experience of the past 30 years, however, has seen spending grow at a much higher rate in relation to income than has been the experience of other nations, a rate that is clearly too high.

ACHIEVING COST-CONTAINMENT GOALS

The Commission has not yet made any recommendation on the desirability of global budgets or expenditure limits as a means to assure that systemwide cost-containment goals are achieved. It has been debating the merits of both rate setting and premium limits for achieving these goals. In particular, the Commission has analyzed the system's ability to put either approach into place quickly and has focused on how each might be implemented without inappropriately influencing either access or developments in the delivery of care.

Rate setting draws on the experience of the Medicare program in developing mechanisms for setting payment rates for hospital and physicians' services and applies it to private payers. Although this approach to cost containment makes sense for fee-for-service plans and out-of-network use in other plans, it does not so easily accommodate managed-care plans. Although rate setting could be made compatible by exempting some managed-care plans, this approach would leave managed care without any constraints other than the market. Although the potential for cost containment under group-model and staff-model HMOs has been demonstrated, it remains unproven for other types of managed-care plans. Moreover, the line between categories of plans is very difficult to draw. Many policymakers would prefer that cost containment accommodate these trends -- rather than restrict managed care to traditional models -- while assuring some accountability for future cost growth.

Premium limits are viewed by some, including the Administration, as a more appropriate approach to cost containment, because they leave each plan the flexibility to determine how best to achieve spending goals. Premium limits are most appropriate for managed-care plans, but could work for fee-for-service plans if accompanied by fee schedules (as in the Administration's proposal). The Commission is currently examining the system's ability to initiate a policy of premium limits at the outset. In general, the Commission is looking at the possibility that premium caps could create unintended inequities because of data problems, the inability to adjust adequately for risk, and the entry of new plans into markets.

The Commission has previously commented on the limited databases available to set expenditure limits at either the state or substate level. New data are coming on line, but their reliability and completeness remain untested, especially at the substate level. The Administration's proposal will rely on the data available in 1995 to implement premium limits. Because the Commission has yet to see the Administration's assumptions about

77-602 O - 94 - 2

the databases and methods to be used, it remains less optimistic about how well this task can be accomplished.

The Commission has studied the issue of risk adjustment and remains uncertain about the adequacy of current models to control adequately for risk selection. Although a variety of risk adjusters and risk-sharing mechanisms can be incorporated into the system from its start, it is clear that a significant proportion of risk selection will remain unmeasured and unadjusted. To the extent this is true, premium caps may put more pressure on plans that have drawn more costly enrollees and may risk endangering access for these people.

The use of historical baselines for premium caps may mute some of the problems associated with unmeasured risk selection or data gaps. But, under such a system, a particular problem is posed by the entry of new plans into the marketplace. It is easy to imagine plans being disbanded and replaced by new plans (perhaps in name only) simply to get out of a historical baseline that is too low. The Commission is exploring ways to blend caps based on historical baselines with those based on fixed premium levels.

Finally, some make the argument that it is important to give market forces a chance before imposing premium caps. The Commission is studying whether such a strategy would be more effective if accompanied by a policy of standby premium limits triggered if certain spending growth goals were not achieved in the first few years under reform. Under such a policy, it would be critical to develop the data capability to provide timely tracking of expenditures at state and substate levels and to determine how a standby system would be triggered. Similarly, this policy would allow for continued development of methods to establish premium caps.

As it proceeds with its analysis, the Commission is cognizant of the budget scoring implications of a standby system and is looking into whether increased revenue or a slower expansion of coverage would be necessary under this approach. In addition, it recognizes the need to avoid a situation where the standby use of premium caps would interfere with success of market forces, possibly by assuring plans that their current premium levels would not be used as a base for limits in the future.

SETTING EXPENDITURE LIMITS FOR STATES AND ALLIANCES

In a system that would set limits at a state or substate level, policymakers are confronted with the need to devise a strategy for addressing the substantial variations in historical rates of per-capita expenditures around the country -- the twofold spreads that currently exist from the highest-spending states to the lowest. They would have to decide whether these different levels are the right starting points for requiring states or alliances to control costs or whether states or alliances would be required to meet a common expenditure limit after a period of years.

The Administration's proposal reflects a reasonable conclusion that -- in the short term -- the only viable strategy is to hold each state or alliance accountable to its own historical baseline. That proposal calls on the national board to send recommendations to the Congress for reducing the variations among states in the future.

The use of separate historical baselines to set targets for each state is attractive because it does not impose unrealistic requirements on states to meet a common target

in the first few years. Regional variations in the practice of medicine are substantial, and this approach incorporates some of the differences between states -- in input prices, demographic makeup of the population, and morbidity -- without the need to measure them accurately. It also recognizes that other differences, such as excess capacity and the provision of inappropriate care, cannot easily be changed in a short time.

The use of historical baselines, however, creates several technical challenges. First is the availability of data from which to create baselines. Newly published data from the Health Care Financing Administration (HCFA) provide a starting point for establishing baselines for states. Additional data, however, would be needed to set baselines for alliance regions. Even if alliance regions follow the lines of metropolitan statistical areas (MSAs) or counties, aggregate spending data are not commonly available for these entities. Setting accurate historical baseline targets for these regions is likely to be a difficult task. Preliminary analysis of Medicare data by the Commission suggests that variations among alliances (if defined as MSAs) are at least as great as those among states. Further research is needed to understand better the variations across states and regions and the extent to which such variations can be reduced in a short time frame.

A second challenge is the set of adjustments necessary for HCFA's estimates of spending to serve as targets. In particular, these data are provider-based, not person-based. Thus, any time a state's residents cross a state border to receive services, those services are counted toward the state where the provider is located. Second, these estimates would have to be adjusted for use in setting targets to account for those population groups that would not be included under the alliance system (for example, Medicare beneficiaries and employees in large corporations). Third, cost sharing is considered off budget since it is not included in premiums; accordingly, targets would have to be decreased to allow for the estimated proportion of spending that would be paid out of pocket by consumers in the form of cost sharing. Finally, targets would have to be increased to cover the increased utilization that would occur as a result of providing the standard benefit package to all Americans.

The Commission has done a preliminary analysis of the effects of two of these adjustments: those for border crossing and for increased utilization by the uninsured. This analysis shows the potential for large shifts in state targets, illustrating the importance of these adjustments. Eight states and the District of Columbia, for example, would find their targets adjusted by 10 percent or more. Both the Commission and HCFA are undertaking research to calibrate these and other adjustments.

Generally, to the extent that historical baselines are not set accurately, budget pressures on different states and regions and on the plans offered there would become inequitable, potentially affecting access to care in those areas. Such an imbalance would create the need for mid-course corrections on a budget-neutral basis or could lead to political pressures for a loosening of targets in some areas.

The use of separate historical baselines also has the disadvantage of locking into place various inequities among states. Consider two types of low-spending states: (1) one that has already achieved greater efficiencies in its health system due to state-level reforms or to private-sector developments and (2) one that currently lacks the capacity to provide access to services for its insured population. In the first case, the budgeting process might penalize the state for its success in reducing the amount of unnecessary and inappropriate services provided to its citizens. Health plans within the state would have little or no margin to adopt new technologies or otherwise to expand capacity in contrast to a state with a higher historical volume of services. In the second case, the

budgeting process would constrain the state's ability to expand access to its underserved population because the budget locks in the historically low level of services. Poor access for uninsured populations would be accounted for in revising historical baselines to set the initial targets, but there is no basis for making adjustments for poor access to already insured populations.

The second strategy for setting targets entails basing each state's target on an overall national target, making adjustments only for certain uncontrollable differences. These factors might include differences between a given state and the national average in (1) input prices, such as local wage rates and office rents; (2) demography, such as age distribution; and (3) health status and epidemiological factors.

The advantage of this strategy is that it places all states on the same terms and avoids penalizing states that have already achieved efficiencies or that need to increase services to underserved populations. It might also diminish some of the data needs, since accurate historical baselines would not be needed for each state or alliance region.

Although this approach might make sense in the long term, its main drawback lies in the substantial differences that exist currently. Preliminary analysis by the Commission suggests that it is unlikely that most of the current variation in spending by state could be explained by the types of adjustments listed above. Experts believe that much of the state variation results from differences in practice patterns and utilization levels for underserved populations, which in turn reflect variations in income and prevailing opinions about best practices. Factors such as system capacity (e.g., number of physicians or number of hospital beds) that appear to drive levels of utilization can be changed, but such changes may take many years to accomplish.

FEE SCHEDULES IN HEALTH SYSTEM REFORM

Regardless of the shape that health system reform may take, the Commission believes that fee schedules can play an important role. In approaches that involve expenditure limits, fee schedules may be critical to the ability of fee-for-service plans to meet premium limits. Even in the absence of global budgets, the Commission believes that fee schedules can play an important role in realigning incentives faced by different types of physicians.

The Commission believes that a federal relative value scale (RVS) should provide the basis for fee schedules used by private payers around the country. Development of a federal RVS should start from Medicare's RVS. But certain additional modifications are critical. First, as recommended by the Commission for Medicare, resource-based practice expense payments should be incorporated into the federal RVS in place of the current system of historically derived practice expense payments. Second, refinements should be made to the relative values for those services not normally part of Medicare's benefit package: preventive services, obstetric services, and services unique to children.

Furthermore, as with Medicare's payment reform, limits on balance billing should be an integral part of such fee schedules. Limits are important to constrain costs to patients and avoid barriers to access. At the same time, an allowance for balance billing may serve as a safety valve for physicians who do not perceive the fee schedules as adequate. The limit on balance billing for private plans need not conform to Medicare's level, and the Commission envisions that it would be a higher percentage.

STRUCTURING COMPETITIVE MARKETS IN HEALTH SYSTEM REFORM

Alliances or health insurance purchasing cooperatives have been proposed by many policymakers, including those in the Administration, as a way to structure competitive markets. Some critical functions that might be filled by such entities include the enforcement of community rating, risk adjustment, and the administration of the rules of competition. All such functions could also be performed by governments, and the critical question is whether alliances are useful structures for performing them.

The Commission has been exploring the merits of different models for organizing markets. Under reform approaches that include budget limits, some Commissioners believe that those responsible for administering limits could play an active role by using their judgment in constructing and enforcing premium caps to meet a budget constraint. A continuing concern, however, is whether such discretion should be delegated to a nongovernmental entity.

The Commission has also expressed considerable interest in the idea that, where metropolitan areas cross state boundaries, these areas might best be treated as single regions. Various options might include creation of a single entity responsible to two or more states or joint efforts by those entities operating in adjoining states. These options raise issues of how community rating might operate and how state regulation of plans could be maintained.

COMPLEMENTARY POLICIES FOR COST CONTAINMENT

A system that combines expenditure limits with these structural reforms would provide a backstop to ensure that savings are achieved. The success of either approach, however, would be enhanced by complementary policies that provide tools for health plans and providers to control costs. These policies would decrease the pressures that fuel cost increases, thereby reducing the degree of dependence on expenditure limits to meet cost-containment goals. The Commission has previously recommended to the Congress several such policies that would facilitate achievement of both short-term and long-term goals.

Controlling the Supply and Specialty Mix of Physicians

Growth in physician supply and imbalance in specialty mix both contribute to the rising costs of care. The success of other reforms to rationalize delivery systems and slow growth in expenditures may be undermined unless accompanied by limits on capacity. Spiraling growth in residencies, primarily to meet the service needs of teaching hospitals, has particularly frustrated past efforts to effect change.

To address these concerns, the Commission has recommended a system of graduate medical education (GME) consisting of five components (1) a statutory limit on the total number of residencies; (2) a federal commission that uses a deliberative process to determine the distribution of these slots by specialty; (3) decisions by accrediting bodies to select funded residencies based on educational quality; (4) payments for the direct costs of GME from a national financing pool to which all payers contribute; and (5) targeted relief to teaching hospitals that lose residents.

While the Administration's proposal is similar in many respects to this policy, it diverges in two key areas. First, it permits (but does not require) a limit on the number of residents. This may reflect the view that with the growth of managed care, limits on

capacity will emerge as plans hold physicians accountable for resource use and outcomes. There are questions, however, as to how quickly this will happen and the risks in the interim. If the fee-for-service sector remains substantial, physicians will still be able to affect demand for their services, pushing up expenditures with each additional physician trained.

Second, the Administration's proposal would set in statute specialty mix goals, about which objective data are not currently available. This proposal has already spawned a scramble by specialties seeking to be labeled as "primary care." The Commission would prefer to see the federal commission make these decisions.

National Data Strategy

A national data strategy could provide the basis for achieving certain administrative efficiencies as well as a stronger database for supporting both the use of profiling by health plans and other entities and research on the effectiveness of medical interventions. The Commission's recommended strategy would include standardization relating to data elements, forms, unique identifiers, and confidentiality. It would also include the creation of regional data organizations that would meet such needs of health system reform as enforcing expenditure limits or monitoring quality and access without a total restructuring of the way data are collected and processed. The Commission is also considering a recommendation for data clearinghouses that could offer considerable administrative simplification.

Outcomes Research, Practice Guidelines, and Coverage Decisions

Practice guidelines and expanded funding for research on medical outcomes could provide information to physicians to enable them to practice more effectively and efficiently. These tools would also be essential to plans seeking to reduce costs, whether motivated by market pressures or federal premium caps.

A related issue is that of coverage decisions under a standard benefit package, which most reform proposals envision. Decisions on what services are covered will play a critical role in controlling costs. The Commission supports an expansion of technology assessment activities so that these decisions can be made on the basis of solid information both on the effectiveness of medical services and on the costs of those services. Many proposals have not included costs, and the Commission believes that this omission is a serious mistake.

Medical Malpractice Reform

Medical malpractice reform could both lower costs and improve quality of care, and the Commission has made several recommendations in this area over the past two years. Specifically, the Commission recommends adoption of the types of tort reforms included in the Administration's proposal but goes farther by calling for limits on noneconomic damages. It is less sanguine than the Administration about the effectiveness of current certificate of merit programs and alternative dispute resolution systems and would recommend against required use of these procedures.

More generally, the Commission believes that the types of measures in the Administration's proposal will make only a limited contribution to achieving the central goals of a medical malpractice system: to reduce preventable medical injuries and to compensate patients when they occur. It envisions a future system that would consist of an administrative mechanism for efficient compensation and a parallel system for

monitoring, quality review, and other measures that would reduce the rate of injury. The Commission included in its 1992 annual report a series of recommendations to pave the way for such changes through development of more efficient systems for compensating injured patients (including more reliable standards for compensation decisions), better data on medical injuries, and systems to prevent injuries and improve quality of care.

Chairman ROSTENKOWSKI. Gentlemen, the President's plan for controlling costs begins with the establishment of a national budget. Now, given the current state of knowledge and data, is it possible to set and implement an enforceable national health budget within 1 or 2 years? Is it technically feasible to allocate the national budget to States or other smaller areas as proposed in the President's budget? And what are the major issues in setting and allocating a budget?

Would either of you like to answer that?

Dr. EISENBERG. Well, let me start by just saying that it is probably technically feasible to do so, presuming that we are willing to live with whatever mistakes exist in the current database that we have. It probably is technically feasible to do so, but we are anxious about the adverse effects that might exist from setting those limits too quickly. We believe that the distortions that currently exist and the inequities that could exist were we to set those limits too quickly would be serious. Therefore, we are concerned about a premature establishment of tight limits, but we do believe that it is both technically feasible and needs to be carried out by some date that is more than 1 or 2 years from the present time.

Mr. ALTMAN. Mr. Chairman, we have experience in the Medicare program of going from a cost-based hospital reimbursement system to perhaps the most complicated payment system ever devised by man in this world, called the DRG system, which has given a lot of us employment but was not well understood by very many when it was first introduced in 1983.

And I think there are two things one could learn from that. One, it is possible to make major changes in the payment system without destroying the health care system. Although it was also true that we sort of made a few little mistakes which generated an extra $5 billion flow to the health care system that wasn't intended.

We have not as a Commission made any calls on that, but I would make two comments about that. First, I think if you are going to do it, you have to start from where we are. I think it is a mistake to come up with any theoretical appropriate or different strategy than what is existent in the marketplace for the last 20 years. That is what the DRG system did. It didn't radically change the distribution of payments at first.

And, quite frankly, if you are going to make a mistake, you are probably better off erring on spending a little too much money in the short run and then ratcheting it down. That is what every country that I know did. The Germans did that, the Canadians did that, the English did that, the French did that, rather than going the other way. Because the other way will generate so much opposition so quickly that you won't have a chance to adjust it.

So it is hard for me to even say this because I know how important it is to control costs, but if you are going to go to a new form of controls, which I think is possible, it should be based on the existing structure at first and then adjusted over time, and, second, it should not be too tight in the short run. Because you are going to have to learn a lot about how it works.

Chairman ROSTENKOWSKI. The President's proposal has a relatively rapid decline in the rate of growth and health spending in

the first few years. Tell me, is that realistic? Do you think we can achieve that decline?

Dr. EISENBERG. Well, I think we could achieve it. The question is, how many consequences that are adverse would there be of achieving that decline that quickly? That is really what we are worried about.

I think we could achieve that decline. We could reduce fees. We could limit access. We could do a lot of things that would achieve that decline in the very, very short term. The Commission, and I think I personally, would say that we really are quite worried about the repercussions of a decline that is that fast. But it is technically possible.

Mr. ALTMAN. If you will permit me, I would answer that two totally different ways. I think if you are going to make very little redistribution of money, I think you can almost stop the growth in the short run. I don't think you are going to be able to hold on to that in the long run, but this is a very big and some would say quite bloated industry that could live with 1 or 2 lean years, provided you didn't make major restructuring changes.

So if you left the flow of dollars roughly in line with where they are, yes, I think you could cut down fairly quickly. If you are going to go to major restructuring, though, then the opposite would apply. I wouldn't do it that quickly.

So it depends on how much restructuring you are going to build in, in addition to cutting spending growth. And, as I indicated, I would be careful about cutting it too tightly if you are going to do a lot of restructuring.

Chairman ROSTENKOWSKI. Thank you.

Mr. Stark will inquire.

Mr. STARK. Thank you, Mr. Chairman.

Stuart, one of the things that is missing, perhaps to the joy of many and the consternation of a few, from the President's plan, seems to be any kind of capital allocation plan. And you have mentioned that we have some excess capacity.

In my own area, for instance, Kaiser, which I think does a wonderful job, Kaiser Permanente, of running a managed care operation in my district, but they are planning to build huge new hospitals as we speak. They are building them. And I have got in the same district, half my hospitals are empty—or half empty. Out of the approximately 6,000 hospitals in the country, there are almost 1,200 with occupancy levels below 40 percent. There are 335 hospitals with occupancy below 40 percent and within 10 miles of another hospital.

Now, I only say that—and I think even the hospitals at this point have—the American Hospital Association is coming out and saying, yes, it looks like we have got a little overcapacity. I hate to even bring up the word certificate of need, but that was the extreme of the past years, which in some States worked and some States didn't.

Ought there not be, in whatever plan we come out with, some way of allocating resources and perhaps in areas beyond where competition might dictate, where you put trauma units where they are in short supply in poor neighborhoods or rural areas, how do you allocate MRIs around the country where we may have too

many or the next generation of high tech stuff? Shouldn't we begin to consider—and I think if the President's plan doesn't really do anything to it—some manner of allocating some of these resources?

Mr. ALTMAN. Mr. Stark, I think you have hit upon one of the most important complicated issues that we have.

Let me make a couple of comments. First, if you look at European countries, every European country that I have looked at——

Mr. STARK. I will be glad to go back any time and look.

Mr. ALTMAN. You and I will go together. We had a good trip before.

I would say that every other—every country that I know of has a capital allocation system, control system, as a key component of their cost containment. And, those capital cost restrictions have worked to keep their systems much tighter than ours. We have the most excess capacity on the hospital side and high-tech side—of any country in the world. So, yes, it can and should be thought of seriously.

Now the opposite is also true. If you are going to rely on the marketplace, which I know you have some concerns about and so do I, but if you are going to rely on the marketplace, I think the people who are in that camp would tell you, and I think that they are right, they need excess capacity as the vehicle to get competition among plans. They know that the ability or willingness of hospitals to give them a discount is conditional upon excess capacity. They fear, with some justification I might add——

Mr. STARK. In other words, it won't work in a good system. It will only work in a sloppy system.

Mr. ALTMAN. Well, that is exactly right. The worst of all worlds would be to have a competitive system where you squeezed out all the excess capacity before they had a chance to compete, because I think the capacity for increased rates would be very high.

So it depends on which way you are going to go. If you are going on a market-oriented approach, then you need to let the market work. Recognizing that, yes, I think over time the market can be a pretty tough——

Mr. STARK. Let me just switch now, if I can, to your colleague, Dr. Eisenberg, very quickly, because you addressed this somehow by suggesting we limit residency slots.

I have one concern with that. It will be done by rich alumni of medical schools who tend to be older specialists, who tend to be very conservative, suburban white males. And they could tend to perpetuate that selection. Once you limit the residency slots, there is a tremendous amount of power put in the hands of these rich alumni who control some of the policies of your medical school. Ought we not have some kind of competitive system if we are going to limit residency slots to make sure we truly get the best and brightest without reference to their residential history or their parentage?

Dr. EISENBERG. For recruiting for the residents themselves?

Mr. STARK. Yes.

Dr. EISENBERG. I think you are right. There should be competition. And, indeed, there is very stiff competition for the most selective residencies now, and I think that that should continue. The question, of course, becomes in many ways similar, how fast do you

want to reduce the capacity of the training system and then who would no longer have access to those training sites?

I think with the most competitive approach, which would judge the residencies on the basis of their quality and then judge the candidates on the basis of their quality, that we would have a much better training system than we currently do. But, in the short term, there are institutions that are training sites that are dependent upon those residents for the delivery of care, and we have got to be sure that we don't pull the rug out from under them.

Mr. STARK. Thank you. Thank the panel very much.

Chairman ROSTENKOWSKI. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Dr. Altman, I know it is difficult to project forward because you have to base it upon certain assumptions that may or may not occur. I know in previous discussion in front of the subcommittee, we have had some good exchanges with others in which I think you and I agree that some of the changes are probably more structural and long term than others would admit.

My question is this: In looking at the Clinton plan, it seems to me that it is a conceptual framework focusing on some of the problems that we had in that 1988 to 1991 period, and even 1992. What is most remarkable to me is what is occurring at the State level and in the private sector, especially in 1993 and perhaps even in 1994. As we get data on things like the voluntary HIPC in California and the continued restructuring of the way in which managed care is taking over, would it be very helpful if you had a sneak peek at 1994 in preparing some of these assumptions prior to us locking ourselves into a solution for a problem that no longer exists the way it existed at the time it was formulated?

Mr. ALTMAN. Well, there is no question that our ability to project the future is notoriously bad, because history has a way of making turns and twists that our projecting methodology often misses. I mean, if we didn't have 1993 data and we just stopped in 1992, we would have had a very different cost structure than exists today. And, yes, if you would give me 1994 data, I think we might find it looking very different even than today.

But I also think it is fair to say that the President's plan does not go against the grain. I mean, you may say what you want about it, but it is—it planted itself and set its direction in the direction where the currents are moving us. And that is it is moving in the same direction where I see a great percentage of our country moving.

And so I personally do not think the President's plan is as radical as some ways it could be. A lot of moving things around, a lot of different people playing in there, but basically pushing the boat in the same direction that it is already moving.

Mr. THOMAS. How do you reconcile that with what I thought you said at the end of the comments to the Chairman? Did you mean that major cost cutting can be done or major restructuring can be done, but it is probably not a good idea to do both? Is it fair to say the President's plan is major restructuring and major cost cutting at the same time?

Mr. ALTMAN. No, I think the President's plan calls for an allocation to the States based on historical spending and then tries to do

it tightly. And, as I said, if you are going to have a tight, fast cut, then don't try to mess around with the redistribution. My fear is you try to do a little bit of both.

Once the Congress—if you will excuse me—gets its hands on these numbers, they say, wait a minute, I want more to go to State *x* and less to go to State *y*. If you do that—and you can make a good case for it I am sure—then I would suggest go slower.

So the President's plan calls for a tight limit, maybe even tighter than I might push for, but it doesn't call for as much restructuring of the money as others have suggested.

Mr. THOMAS. Dr. Eisenberg, in terms of our inability right now to do risk adjusting in a way that is going to be critical to setting up the plan, I think everybody acknowledges that. However, it is kind of like some of the new construction approaches, that is, you have faith the components are going to end up being finished at the same time.

Couldn't we, in some instances, get some insurance in making sure that we are right if we take a look at—and I would invite your reaction but I don't have a lot of time left, and we may be able to do it in the second phase—about some of the experiments that are going on in States right now, California being one of them, New York and others, in terms of trying to come up with some workable models on the risk adjustment?

Are there other things that we could do internally that make more sense? That is, front load the administrative simplification so that we can collect data in a way that will help us move forward or not go immediately to community rating and hang on to some of the known factors that we are comfortable with and add then items as we are more comfortable with them?

My concern is that if we go immediately to this complete change and risk it all on our ability to do risk-adjusting mechanisms, we are probably going to fail.

Dr. EISENBERG. Well, we share your concern about the current methods of risk adjustment that are available.

I think you are right in two ways. First, we should build into the system mechanisms so that the plans and the alliances must collect data that we currently don't have access to, collect it in a timely fashion, process it in a timely fashion. To that end we have recommended consideration of data clearinghouses where the data could become much more quickly available. We have to, of course, then decide what data we want, what data would predict risk, but we can't even use the predictors we have unless we can get the data. That is one issue.

The second is that there are elements that could be built into a plan ahead of time to try to avoid the problems that risk adjustment brings. For example, there could be safeguards—as there are in the President's proposal—to try to avoid cherry-picking or cream-skimming, whichever term you want to use. Rules should eliminate those mechanisms where a company or plan avoids risk by the way in which it markets or the way in which it sets up its physicians or its hospitals.

And I think it is critical that we make it difficult if not impossible for plans to cherry-pick or cream-skim.

Another issue is the one that we addressed in our prepared testimony which has to do with the geographic boundaries of the areas. If, in fact, we were to create a geographic boundary that would include predominantly those who we suspect are going to be at high risk of incurring severe disease, it is going to be unlikely that plans will market to individuals in those areas. And so redefining the geographic boundary so that it is more heterogeneous might help us to deal with some of those problems that risk adjustment won't be able to correct more.

Chairman ROSTENKOWSKI. Mr. Levin.

Mr. LEVIN. Thank you for your testimony. You have a welcome objectivity if anybody is objective about this—and you sometimes give us answers we don't expect or like, which is refreshing.

Let me ask you about a couple of areas. Dr. Eisenberg's testimony says "Regardless of the shape that health system reform may take, the Commission believes that fee schedules can play an important role."

I am not sure all sides of this debate would agree with that. In terms of the President's plan, there has to be a fee-for-service option, and companies would be able to participate in that if they met certain requirements? Presumably the alliance then makes the payment to the carrier; right?

Dr. EISENBERG. Yes.

Mr. LEVIN. One question that has been raised is why is there a mandated fee schedule? In other words, the alliance is mandated to establish a fee schedule or the use of one if the State has an all-payer system. Why is this necessary within that conceptual framework?

Dr. EISENBERG. Several reasons. One is that we believe that a fee schedule, especially one that is constructed the way that the Congress worked out the Medicare fee schedule, provides incentives that are salutary; that it encourages primary care and it encourages cost-effective delivery of care, and therefore, that fee-for-service plan is likely to be able to stay within its budget and deliver the kind of care we would like to see delivered through use of a fee schedule of that sort.

Second, it provides a mechanism whereby the equation of price times volume equals total expenditures can be used in order to adjust those fees depending upon what the volume increases have been; so that there will be a relatively easy calculus of changing the fees based on changes in volume.

A third reason is that it becomes predictable from the perspective of the patients. They know what they are facing if they understand what the fee schedule is and what the conversion factor is—if there is in fact a constraint on balanced billing, as we have suggested. It becomes obvious to the consumer what he or she is going to be facing if those fees are widely available.

The last reason which gets to the question of why we believe that there ought to be a fee schedule based on the Medicare fee schedule is quite frankly that we think it works. We think there has been a tremendous amount of work put into that fee schedule. It is being refined. A substantial amount of societal resources have been invested in that fee schedule and we believe it ought to be used as widely as possible, that it would create equity and a better mecha-

nism of competition across plans if in fact what they are competing on is the quality and access to care that they are delivering.

Mr. LEVIN. My guess is this is going to be a subject of major controversy, whether it is absolutely essential that you have a fee schedule within each alliance. I think we all need to think about that further because when the insurance carrier sets its premium, it accepts a certain risk.

I want to talk to both of you about the alliances. Dr. Eisenberg's testimony says "All such functions could also be performed by governments, and the critical question is whether alliances are useful structures for performing them."

If there isn't time now, I would like at some point to get your further input on this, because a number of us have been talking about this. I will give you one example quickly and unfortunately there won't be time to respond.

As I understand the way the alliances are going to operate, the fee or the premium that would be charged to both spouses in a working couple would be the same as the premium charged to a single spouse in a couple in which only one spouse is working. In other words, all spouses would be charged the same, whether one or both work. The argument is that this greatly simplifies employer premium payments. Separate calculations do not have to be made based on the working status of each spouse. The payment amounts are set by the alliance based on the average number of workers per family.

Thank you Mr. Chairman.

Chairman ROSTENKOWSKI. Mr. Cardin will inquire.

Mr. CARDIN. Thank you, Mr. Chairman.

I want to follow up on Mr. Levin's point on setting fees. I am not sure how you could enforce the budgets without some form of rate-setting and I am glad to hear your comments about the necessity of having a rate structure.

In Maryland for hospital rates, as Dr. Altman well knows, we have a rate structure which has been effective in keeping our rate of growth below the national average.

If I understand you correctly, you are talking about a rate structure that would apply not only to the Medicare payment, but to private insurance also. Would that be the same rate paid for Medicare as would be paid for private insurance as you envision it using the same methodology?

Dr. EISENBERG. Not necessarily. The rate might not be exactly the same because in order to stay within the budgetary limit, the fee will depend not only on what the rate structure is, but also upon the volume. So the conversion factor might differ based upon overall expenditures in the plan.

The scenario we are painting is one in which the relative values could be similar, but the absolute fee would depend upon the ability of that plan to stay within its budget and then alter its conversion factor. I think Paul would like to add to that.

Mr. GINSBURG. Today the average payment rates paid by private insurers are so much higher than those paid by Medicare that it is inconceivable——

Mr. CARDIN. Because of cost shifting, it would be too radical a change immediately to shift to everyone receiving the same pay-

ment structure. Do you envision the rate-setting being done by the local alliance or by the State government? It does not have to come out of Washington, does it?

Dr. EISENBERG. No. It could be done at any level. We recommend that the technical work that has been done to establish the relative values be strongly recommended at least and that it be the basic framework, but the adjustments could be done at the local level.

Mr. CARDIN. It could be a State all-payer rate structure understanding that that would have to over some time, because of the cost shifting that currently exists in our system and the radical change occurring too quickly, could cause some major disruption problems, but I take it from your testimony it could be an all-payer rate system developed?

Mr. ALTMAN. I think a more realistic outcome in the President's plan would not be the initial use of those rates. If you put on a tough limit that the plans can't meet, then there is an automatic adjuster built into the plan which forces back a proportional downward adjustment that each plan would then recover from the providers. So what is more likely to happen is that if you put a tough limit on the premiums that the market doesn't generate and they go over it on an average basis, this automatic adjuster goes in for all plans that exceed that average and then there is a proportional adjustment.

The fee schedules will not take place with those plans.

Mr. CARDIN. I think the point has been well made that one of the most effective ways to make sure you stay within any cost containment is a rate structure and we can argue specifically about how it is framed.

Dr. Altman, I want to emphasize a point that you made, and that is that without some enforceable cost containment, the real losers are going to be those who have private insurance because the political dynamics are such that we are going to continue to see cuts in the Federal reimbursement programs under Medicare. Unless we get real cost containment in place, enforceable cost containment in place, it is likely that if you go back to the historical cost increases in hospital care, we are going to ask people who have private insurance, the employers and the employees, to pay even a larger percentage of the cost than they are today, which may well cause some private employers to give up their insurance and even add more to the uninsured population.

Mr. ALTMAN. Absolutely. As we saw recently, the number of uninsured grew by over 2 million. There is a potential for an unfortunate dynamic to take place, and that is what you said, more cost shifting, more employers dropping their coverage, the number of uninsured growing, which leads to even more cost shifting, which leads to further drops in coverage.

We were spared some of the dynamics by a liberalization of the Medicaid program during the 1980s. If that were to stop or reverse itself, you will see the number of uninsured in this country potentially grow and shoot right through the 40 million number.

Chairman ROSTENKOWSKI. Mr. Bunning.

Mr. BUNNING. Thank you, Mr. Chairman.

Dr. Eisenberg, I would like to follow up on Mr. Cardin. In your testimony, you mention that reforms could achieve long-term cost

saving either through rigorous competition or expenditure limits that would give strong incentives to discover ways to weed out inappropriate care and move more carefully into more cost-effective settings. Surely this is a goal of what we are trying to do.

You go on to discuss how our ability to properly set rates, limit premiums and make them fair across States is limited. What happens if we set premium limits and payment rates that are appropriate or inappropriately low either because our method for setting them is poor or because somehow those setting the limits are under pressure generated by budget problems and can't reduce benefits for political reasons, and we just want to assure we don't spend too much?

Is it not possible if we ratchet down too hard on the payments putting them at or below cost, we will create serious access problems similar to what we have seen in the Medicaid program?

Dr. EISENBERG. Yes. We are concerned about that. As a Commission, we continue to collect data on the access to care for Medicare beneficiaries. We are focusing on the current system so much because the data at least exist there. We have noticed that over the past several years that the difference between the Medicare rates and the rates that are available commercially has widened so that Medicare rates are below 70 percent of the commercial rates.

We haven't any data yet that access to care for the elderly has been limited, but are starting to hear anecdotes that it might be. We have data that we hope to be able to present to the Congress within the next few months that will tell us whether or not there is any measurable decrease in access.

We are concerned that if the difference becomes as wide at it is with Medicaid, that access or quality could be compromised.

So yes, it is an important issue and it emphasizes all the more the need to continue to get the data and to monitor the system and be sure that access and quality are assured. But I must say as a caveat that one of the reasons why there is a difference between the Medicare rates and the commercial rates some might argue is that the commercial rates could come down themselves and they may be too high. In order to achieve the kind of equity and equal access that we need, we have to look at more collaboration of the funds that are made available for the care of the different members of the population.

Mr. GINSBURG. If I can add something quickly, one possible scenario, if the premium limit is inadvertently set way too low in a geographic area, is that we won't find anyone willing to sell insurance in the sense that the insurance company's actuaries will tell them to stay away from an area; that they can't make a profit or avoid a loss selling at these rates.

The problem could wind up as not having enough supply of insurance.

Mr. BUNNING. What happens under that case? What does an alliance do when there are not enough insurers or there are not enough options for an insurance company to go in and write that?

Mr. GINSBURG. I hope the system is flexible enough that that is perceived as evidence that something is wrong and that changes are made very quickly in order to make sure that enough insurance is available to be written in that area.

Mr. BUNNING. Couldn't the opposite occur? Couldn't people say, "By the way, insurance companies, there is an opportunity to write here and we think these rates are a correct rate"? What I think will happen is the exact opposite of what your scenario would say, that the insurance companies must go in and write that.

So I think that there is a possibility of the exact opposite occurring where an insurance company will be required to go in and take that risk even though the possibility exists that it might not be a profitably-seen venture.

Thank you, Mr. Chairman.

Chairman ROSTENKOWSKI. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Good morning. Old friends back again.

Everybody thinks about quality in this process after they think about access and cost containment. I want to talk about the quality aspects of your efforts at cost containment.

If you set a budget and you control prices, then you control volume and you have one set of ways to control costs, through the budget that is price- and volume-related. But if you do as the President's bill does, which is try to encourage everybody to go to a capitated system, where you are now capitating and you have a number of people and that determines the budget—it is the capitation rate times the number of people that is your budget. How do you ensure that the quality is maintained in those capitated programs when they are competing on the basis of price?

One plan will be $150 a month and another will be $150 and you know that within the plan they are going to be squeezing services to get to that rate. I would like to hear you both talk about that issue.

Dr. EISENBERG. I think one of the reasons that we emphasize the cost and the access issues so much is that they are more easily measured and the quality issues are so much more difficult to measure. I think the President's proposal moves forward in this area, with the idea of having a report that is presented on some of the quality measures that we do have available and that we know are reasonably reliable, and with better measures of health outcomes. We ought to be measuring patient satisfaction with regard to the quality of care they are getting and access to care so we can compare one plan to another; not only so consumers can choose them, but to be sure we are getting what we want to get out of those health care plans.

We are worried as you are that the measures that we have of quality are not sufficient to alert us to differences in quality that might exist until they become large differences and maybe even manifest themselves in outcomes.

Mr. ALTMAN. I think the issue of quality/access is a real one regardless of whether you have managed care plans or not. Clearly in other countries, Canada for example, and you are beginning to hear it in Germany as well, if you impose tight budget limits on a hospital as they do, or impose tight payment restrictions on physicians as they do, quality keeps coming up in the local newspaper and the like.

So I think the issue is how tight a limit you impose. I think your comment, though, is very appropriate. It is more transparent in

these other systems when quality deteriorates. In the managed care plans, there is a lot going on beneath the surface that you can't see. So we do have to become much more sophisticated to understand what is quality and what is going on.

There are people, of course, that at the first sign of any cuts would argue that there is a deterioration in quality. On the other hand, HMOs have really never faced a tough, tough budget world because they have been competing against a fluffy, fat, fee-for-service world. I think we are all in for a new world if we impose the tight budget limits we are talking about; so I think your issue ultimately is very real.

Dr. EISENBERG. I am speaking for myself and not the Commission here, but I am very concerned about the fact that the regulation of the plans will be as local as it is. I am concerned about whether the resources to evaluate that quality will exist in every alliance and every locale even if there is national support for the process, in particular with as many of the plans being national plans as they are and offering care across State boundaries.

I think we need to consider whether the accountability of the plans to society in general, however that is defined—alliance, Congress or Federal agency—is adequate. I have great concern about some of the plans and the degree to which there are remarkable incentives for them to cut corners to decrease access and to decrease quality and the more incentives that exist, either to their own pocketbooks or to their market share, for them to decrease quality. I think these factors mandate that we have a very effective and forceful program in place to make sure that doesn't happen and that we regulate the plans to make sure that quality is maintained.

Mr. MCDERMOTT. You allude to one of the problems that concerns me, which is, in a managed care plan, you have a so-called gatekeeper, some mechanism by which when people come in, they see a general medicine person before they are referred to a specialist. Many HMOs are writing contracts saying to the doctor who is the gatekeeper, "You will make more money if you don't make any referrals."

I wonder if there is any data to suggest that you know how many referrals a gatekeeper ought to make to be within the realms of providing good care? When I was in medical school, they said if you didn't take out 10 percent normal appendixes, you weren't doing enough appendectomies because you couldn't always be right. So there was a 10 percent slush factor in that procedure.

Is there data available about the number of referrals from a general practitioner by which you could make any kind of judgment as to whether they were making enough referrals to specialists?

Dr. EISENBERG. We do have data on the referrals that exist and we could look at referrals that exist within organized systems of care that we believe are effective; Kaiser, for example.

We also have an emerging list of guidelines for care that would suggest to us when a patient ought to have a diagnostic test or procedure performed, and we could use those to measure as well. I don't think there is a score card that we could turn to that would suggest to us at this point at least that a particular generalist is above or below the line on referrals.

Mr. McDERMOTT. How long do you think it would take to develop that?

Dr. EISENBERG. I think that could be done within a relatively short period of time. It would have to be modified. I think within 1 year or 2 we could at least develop a model or demonstration projects if not something we are ready to disseminate.

Mr. PICKLE [presiding]. Mr. Payne.

Mr. PAYNE. Thank you, Mr. Chairman, and I thank the members of the panel for their testimony.

We all start with the premise that health care costs are too high. Dr. Eisenberg, you said in your testimony that that was a conclusion that had been reached with regard to the percent of GDP spent on health care in this country versus other countries. We also are seeing that the rate of increase will make it an even higher percent of GDP, so consequently, one of the purposes of health care reform is to try to find a way to reduce that rate of increase.

I understand that the recent data suggests that the private sector, in terms of rate of increase, actually shows that the rate of increase is increasing such that in 1992 the rate of increase was slightly less than 8 percent; whereas in the public sector, in spite of all efforts that we make and you make to ensure we control costs, we find that the rate of increase there continues to be a double-digit rate of increase.

My questions to you are basically two: What is going on there? Are there lessons to be learned in terms of what the private sector is doing that we might benefit from in the public sector? And two, are these lessons a part of what is being proposed in the President's health care reform package?

Dr. EISENBERG. There are two sets of lessons here. One is a lesson about the total public sector and the other is Medicare. I think if we look at the total public sector, many increases in expenditures have to do with eligibility for Medicaid, what is happening in Medicaid plans and issues that Congress has not tried to deal with as much as it has with the Medicare plan.

In Medicare, in fact, the experience is quite the opposite. We have seen a decreasing rate of increase, and since the institution of the Medicare volume performance standards, we have seen a substantial decrease in the rate of growth in physician services. Whether it is cause and effect, we can't tell you, but we have seen a substantial decrease there in a way that I think is quite reassuring of the ability of Congress to help to decrease the rate of increase in health care expenditures.

Mr. ALTMAN. Let me also comment on that. I would support what Dr. Eisenberg said. In those areas of the public sector where the public sector is focused on controls, physician expenditures and hospital expenditures, I think the Medicare program has done a good job. The big growth has been in the areas where utilization is growing quite rapidly, outpatient and home care services and as was pointed out on the Medicaid program payments to States for disproportionate-share hospitals.

I don't think you can draw lessons necessarily that the public sector is not able to control spending. But I think your comments are also fair. Where the public sector is not nearly as effective as the private sector is on utilization controls.

The private sector, through managed care and the like, seems to be doing a much better job on utilization controls than the public sector. We have been doing a better job on price controls, but have no real effective controls on utilization as they do in the private sector. Using the volume performance standards, helps them, and we on the hospital side, using the DRG system, have helped within the hospital; but when you get to home care and outpatient services, that is where the growth items are.

Mr. PAYNE. Yesterday we heard from the National Governors' Association and they commented on Medicaid because they are very much interested in that since the States bear half the cost. They mentioned that they felt that if Medicaid became a managed care type of delivery system, that there were substantial savings that might be realized there. Would you concur with that?

Mr. ALTMAN. Well, I think to the extent that managed care has shown itself to be effective in controlling utilization, I think there is real potential for savings in the Medicaid program. I think one needs to deal with it quite gingerly though, because you are dealing with a population that lacks the kind of market clout and ability to move what the private sector does.

So, yes, I believe there are substantial benefits to be gained, but I do think it needs to be monitored quite closely.

Dr. EISENBERG. We agree. We looked at this recently and concluded that there was some optimistic evidence from the Medicare demonstration projects and from the managed care programs within Medicaid that they might be able to save money. When you look at it very closely, the most substantial decreases seem to be in services such as emergency care.

I must confess we are concerned about whether that is an actual decrease in utilization or simply the fact that the managed care programs are refusing to pay for those emergency room visits and somebody else is having to pick up the cost. While the early data are encouraging, I would add the caveat that the final results aren't in. We don't know where we are squeezing this balloon, where it is popping out somewhere else, or whether it is being contained as a decreased rate of growth on the Medicaid side.

Mr. PAYNE. Thank you.

Chairman ROSTENKOWSKI [presiding]. Mr. Rangel.

Mr. RANGEL. Because I only have 5 minutes, I would ask if you could identify and send me any articles or things you may have written as relates to the cost of health care to the poor. If you can identify them and get to me as soon as possible, because I am having difficulty in understanding how they fit into these alliances.

Yesterday, some Governors said we have to make certain someone pays something and penalize those people that use hospitals for nonemergency matters, and I got the impression over the years that poorer communities have no place else to go, so they use the hospitals more than anybody else. In going to public hospitals, they tell me that it costs—they get reimbursed $7,500 a day for a baby born addicted to drugs; and the intensive care units—I thought it was a unit, it is wherever they put this expensive equipment, and that is much higher.

We have our addicts, alcoholics, AIDS problems, and if the Governors don't want them to use the hospitals—and I can't imagine

doctors forming together, competing for the opportunity to serve in these communities—what happens? I mean, they have a plastic card. Where do they go?

Dr. EISENBERG. We would like to share with you both some material that the Commission has written as well as testimony that we have had during the past 2 or 3 months on this topic. It has been, I think, fair to say, poignant. Some of the conclusions that we would be led to consider at least are that for example, even with insurance, even with coverage, it is very clear that access to care for individuals who are poor or who are African-American is limited and that simply providing them with insurance isn't going to solve the problem.

We could conclude that the distribution of physicians and other health care professionals is such that even if they could pay, they wouldn't be able to get the people near their homes. We could demonstrate that the preventive services that are provided to them are limited.

In our last Commission meeting last week, we spent a substantial amount of time talking with those who are spending full time dealing with issues of the poor under health care reform, so that we could try to weave this into our recommendations for you. We are very concerned about whether there may be people who get left out of health care reform, and if the care that they are provided under health care reform is not mainstream, that it may not be as high quality as we would like to see for them, as well. That relates to both inner-city and rural areas.

We would be happy to get you some of that material.

[Mr. Rangel received the information. A copy is also being retained in the committee files.]

Mr. RANGEL. Is it unrealistic to believe that the government, with local and State help, could have neighborhood clinics with doctors that—with surroundings that lend themselves to high quality care?

In our city, our mayor has established those types of community clinics that work quite well. Are there any funds in this bill that would provide for that?

Dr. EISENBERG. There are funds to encourage physicians to practice in underserved areas, number one, some bonuses that would be offered both in the current Medicare plan and in the proposal. Second, there are provisions for essential community providers and for community health centers in order to assure that they would be available. And then, finally, there is language to assure that hospitals in the inner city would have transition payments so that during the changes in the payment systems they wouldn't get left holding the bag on issues such as graduate medical education and others.

Mr. GINSBURG. The provisions for paying community health centers and other inner-city providers in the Clinton plan are only transitional. I believe they are specified for 5 years. I think that is an issue that is really worth discussion as to whether there should be a permanent mechanism where some people are served by community health centers or where after this transition they need to either become a health plan or, in a sense, contract with health plans, that they can't directly serve residents of the area.

Mr. RANGEL. Because bonuses are not going to attract doctors to these communities, we do need something permanent. If we don't have the doctors, then we have to set up something else. Send me as much material as you can on this issue.

Thank you, Mr. Chairman.

Chairman ROSTENKOWSKI. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

Let me make a couple of statements, one with respect to the budget. I have always contended over the years that I didn't want to see any global budget because I felt that would affect quality care. I have spoken out against it. As we go along, I have come to the conclusion that somehow we have to control costs.

You say, Dr. Altman and others, that if we make a change, the kind of control depends on how speedily we get into it. I say to you that there has to be some kind of enforcement. The only reason we are in a new approach for a new health bill is because costs have gotten out of hand, or else we wouldn't be here.

If costs are now out of hand and too high, then we have to control them, and that means, in some form or another—either in the budget or by target or review later—to have enforcement. I think you, gentlemen, the medical association has to understand there have to be controls enforced and that the Federal Government has to play an appropriate role.

I don't think I want to debate it. Somehow we have to have that control.

Another problem I am concerned about is, when you go to a hospital, the average person, and he spends 24 hours just to crawl in those cool white sheets and get a bill from $800 to $1,500, and it doesn't make a difference whether you just had Tylenol or aspirin or something else. If you had an operation, it may be $5,000. I don't know how you are going to pay for that.

We accept it. The reason is, once you go to that hospital and/or have an operation, you start in motion the biggest paper floating crap game that we have ever known. Nobody really knows who owes what and how much. You can worry yourself sick about it and even get threatened by a credit agency if you haven't paid your bill, when the insurance company says, don't worry about that, the company will pay the bill.

It seems to me that one of the problems is that we accept that system because nobody really pays the bill. Nobody really reaches down in their pocket. We accept it because we say the insurance company or somebody will pay for it. Insurance companies, the providers usually are very slow to pay the bill because they don't really care, in my judgment, how much the bill is or really how long it takes to pay it even if they are the primary payer. But they have got on hand a lot of money not just in reserve, but when you sign up under Medicare for Blue Cross/Blue Shield that means that that company literally has billions of dollars for investment, and I think they often are more interested in the big amount of money they have for investment than they are in paying those bills.

That may be cynical, and I don't intend to be, because they give good service, but the cold fact of the matter is they are relatively slow and unmindful of speed and how they are going to handle it between Medicare and others because they will make more money

on those reserves. The State has regulatory control over it in a sense, but they don't do anything about it. They are only concerned with the minimal level of reserve. So I think we ought to give some consideration, how do you control the amount of money that these big providers get under the payment whenever they sign up for policy?

I don't want to destroy the system, I don't think anybody does; but that is the reason why the costs are so high, and we accept them, and I think it is something we ought to look into.

Let me mention one other proposal—I don't want to debate it—with respect to early retirement. Yesterday, I pointed out the cost under the Clinton plan would be enormous when the government picks up 80 percent of the employees for early retirement; and the other 20 percent, we don't know how much that is going to cost. I asked yesterday for specific dollars from the administration. It seems to me we may be going in the wrong direction.

Number one, we lose the money from the premiums. Second, we miss a lot of money to the Federal Government on income taxes that will no longer come from that. That is going to be a very costly program. If we bail out these big companies, say the automobile companies, if we bail them out with early retirement as their price of support for this bill, and maybe that is desirable, we are bailing out the very people who have the biggest unfunded pension plans that we may be on the hook for. It seems to me like we are kind of working against ourselves.

Now, my time is spent, but I have expressed myself and I think I will be talking to some of you directly for a response later or as we go along. These are concerns I think the public thinks ought to be attended to.

Chairman ROSTENKOWSKI. Mr. Ford will inquire.

Mr. FORD. Thank you, Mr. Chairman. Yesterday we heard from witnesses on the economy and jobs. What I would like to know is, what you believe the impact of health care reform will be on the labor market, specifically the potential for job dislocation in the pharmaceutical, medical device and insurance industries.

Mr. ALTMAN. There is no question that you are not going to have serious reductions in the rate of growth in health care spending without having impact on people. Sometimes I get concerned that people talk about all of these cost reductions as waste and inefficiencies like they can just disappear, have no negative impact on either people or access or quality. Clearly, if you are going to make the kinds of cuts we are talking about, you are going to affect people.

Now, if you focus on one sector like I think in the pharmaceutical area, every indication is that the rate of growth will continue. If anything, it will continue at a slower rate, but it will continue.

The tougher areas for reductions, one you mentioned, which is the insurance and administrative sides. To the extent that hospitals are increasingly cut back as a percentage of the total health bill, they too are going through restructuring. Without reform, we have for the first time seen reductions in staffing in many parts of this country in total, but in total, hospital employment continues to grow but at a much slower rate.

So, yes, there will be some dislocations. Whether it will be made up though in other positive areas is really open for question. My assessment is that when you add it all up, the pluses and minuses, it sort of balances out; and the totality of it—if you include the new jobs that will be created in firms that have lower health care costs, are counterbalanced by reductions in health care areas—that it really balances out. But there will be certain sectors that will have reductions, yes.

Dr. EISENBERG. In our written testimony and in what we have said, we have suggested that the rate of increase be decreased but that we target the rates of increase to gross domestic product plus population growth plus inflation plus perhaps an additional factor. That would mean that the amount being spent on health care would continue to increase even if at a lower rate of increase.

So we may have fewer people coming into the health care sector as employees, but I think we continue see a net decrease so long as we pursue the tack of gross domestic product plus something else.

We will, though, have some redistribution. I am sorry Mr. Pickle left, because I was going to agree with him that we ought to redistribute the money away from the insurance companies. But I think what we are going to see is probably some redistribution, and I hope that redistribution occurs in the way that more services are being offered to people and that we do get rid of some of the administrative and other elements that overlay the health care system that may not contribute to positive outcomes.

Mr. FORD. There are several areas of this country in which a metropolitan area crosses State boundaries. The Memphis metropolitan area extends into neighboring Arkansas and Mississippi. Health care providers and institutions are frequently concentrated in one State while most of the population is scattered across two or more States. The administration has stated that health care networks will be permitted to operate across State lines.

What impact do you believe the State-specific regional alliance boundaries will have on the ability to contain health care costs?

In a metropolitan area like mine where you have two States adjacent to a city that is within a third State will we be able to contain costs for everyone or will some within the metropolitan area pay more for services based on their residence?

Dr. EISENBERG. You can't tell from my accent because I have been away from Memphis for too long, but I spent my first 18 years understanding that northern Mississippi and eastern Arkansas and southwest Tennessee were one metropolitan area. I went to medical school in St. Louis, and I lived in Philadelphia, and now live in Washington, and every one of those metropolitan areas is just like Memphis. People cross the border to get their health care.

We are seriously worried about the issue that you are addressing and believe that some remedy is necessary other than just saying that the plans need to offer access to care through a point-of-service plan. That may help, but we are concerned that it may not offer sufficient access to people to maintain the standard marketplace that has grown up over time in large metropolitan areas that are on rivers or, for whatever other reason, cross State boundaries.

We would like to work with the Congress to try to figure out a way in which that may be done.

We suggest, for example, that a model might be developed where a metropolitan statistical area could be construed as an alliance, but to develop some method of crossing State boundaries to be sure that people who live in northern Mississippi can come to Memphis for their medical care if they want to.

Mr. FORD. Which they will continue to do.

Dr. EISENBERG. The question is whether they have to pay a substantial amount of additional money through a point-of-service plan or whether it will be offered through their regular plan.

Mr. ALTMAN. I would like to offer a counter on that. I think the regional alliances have a better chance of doing that than the State systems because the regional alliances are likely to be much more sensitive to the regional delivery system than even a State, and surely the Federal Government.

I happen to have lived through the health planning era of the 1970s and watched what happened where the Federal Government drew boundaries that crossed State lines, and then the State Governors came in and made it very clear that the line stopped at the State border.

I do believe that these regional alliances will have much more flexibility of moving across State lines even without point-of-service.

The question in the regional health plan is where the person lives, but it doesn't preclude an individual getting health care in the other county or across the State line. It is just a payment flow. I am more concerned about it being dictated from either the State capital or the Federal Government. I think the regions have a better chance of knowing what you are talking about than somebody here in Washington or at the State level.

Mr. FORD. I yield back the balance of my time.

Chairman ROSTENKOWSKI. That concludes this panel. Thank you very much for joining us.

Mr. Newhouse, Dr. Simmons, Mr. Winters, Mr. Meyer, Ms. Wilensky, thank you for joining us this late morning. I am sure that all of you have testified before this committee before. You are all aware of the rules. If you have a long statement and you would like to summarize, the committee will appreciate that because that gives us more time for questions.

Mr. Newhouse, if you are ready to begin, the committee is ready to hear your testimony.

STATEMENT OF JOSEPH P. NEWHOUSE, PH.D., DIRECTOR, DIVISION OF HEALTH POLICY RESEARCH AND EDUCATION, AND A JOHN D. MacARTHUR PROFESSOR OF HEALTH POLICY AND MANAGEMENT, HARVARD UNIVERSITY, BOSTON, MASS.

Mr. NEWHOUSE. Thank you, Mr. Chairman for inviting me here today. It is a pleasure to be here. I am Joseph P. Newhouse, professor of health policy and management at Harvard, and also a member of the Physician Payment Review Commission, but I speak only for myself.

First, in the short run, thinking about the Clinton bill, we can contain costs by getting rid of the waste—the issues are: How large is that waste? How rapidly can those economies be achieved? And to what extent will they already have been achieved when the act takes effect? In the long run, the issues are: How much of the increased capabilities do we want to pay for? How much will demographic factors, such as aging, add? And how rapidly will the economy grow?

I close by echoing a statement that both John Eisenberg and Stu Altman made, which is that, in my view, we will have to look at the adequacy of the data and the size of the investment needed in the data infrastructure if we are to get a handle on health care costs.

Thank you very much.

Chairman ROSTENKOWSKI. Thank you.

[The prepared statement and attachments follow:]

Statements that medical care costs are too high we hear every day, and similarly we hear statements that they have to be contained. A point I would like to leave you with is that when you think about medical care costs, distinguish between the level of those costs at a point in time and how fast they are going up over time.

We have a lot of evidence that the level of costs is too high. We don't have much evidence either way about the rate of increase. Now, how might the level be too high? A lot of evidence of inappropriate services, something that several proposals, including the Health Security Act, tried to address by emphasizing managed competition. Loadings in the small business insurance market are high and can be lowered through the mechanism of the health alliance as many bills propose. Universal coverage will reduce costs for eligibility determination and there are other administrative savings in various bills.

What about the rate of increase? This is not a new thing. If you look at my written testimony, you will see that every decade in the last five decades health care costs went up plus or minus 4 percent per year after taking out inflation and population growth, so in other words, real per capita health spending going up about 4 percent a year except in the 1960s when it went up 6.5 percent. As this committee well knows, that was the decade of Medicare and Medicaid.

Unfortunately, the economy doesn't grow at 4 percent a year, so our share of GDP going to health care has gone up and now stands at around 14 percent. The issues are, what has driven this 4 percent a year increase, which amounts to a factor of 8 to 9 over these 50 years and what has it bought us? I have tried to account for it by quantifying many factors that people talk about to explain the increase, and in the end I am left with a large part of that growth that I can't quantitatively account for. My conclusion is that growth is mainly the increased capabilities of medicine.

Now, to make that a little plausible, I will cite a number of capabilities that weren't around for the most part even 30 years ago, let alone 50 years ago: all kinds of advances in cardiology, such as catheterization, bypass surgery, angioplasty; renal dialysis; transplantation; noninvasive imaging such as MRI; intraocular lenses, even contact lenses; better hearing aids; motorized wheelchairs; and now we stand on the verge of having potentially large expenditure increases from biotechnology, if we want to pay for them.

A second and more quantitative piece of evidence that the increased capabilities may account for this is in exhibit 4, where I look at the G–7 countries' rates of growth, from 1960 to 1990. The data only go back to 1960, which is why I don't have the two earlier decades here. As you can see over the 30 years, the rates of growth are not so dissimilar. Japan is the fastest because it grew very fast in the 1960s, and the United Kingdom is the slowest. Undoubtedly this reflects differences in the rates of growth of income in those countries. In the 1980s, the United States is leading the world, but it is not by a lot.

I see the yellow light has gone on. This leads me to two conclusions for you.

Health Care Cost Containment

Testimony Before the House Committee on Ways and Means
Joseph P. Newhouse
Harvard University
December 16, 1993

Thank you, Mr. Chairman, for inviting me here today to testify. My name is Joseph P. Newhouse, and I am the John D. MacArthur Professor of Health Policy and Management at Harvard University. I am also a member of the Physician Payment Review Commission, but my views are solely my own; I do not speak as a representative of either Harvard or the Commission.

Statements that medical care costs are too high and must be contained abound. However, when thinking about medical costs, it is important to distinguish the level of costs from their rate of increase. There is much evidence that the level of costs is too high; there is much less evidence that the rate of increase is too high.

How might the level be too high? There is evidence of substantial numbers of inappropriate services (Brook and McGlynn 1991), something that the Health Security Act and other proposals attempt to address by emphasizing managed competition. Loadings in the small business insurance market are relatively high and can be lowered through the device of the health alliance, as many propose. Universal coverage will reduce costs for eligibility determination. The mere fact that we spend 40 percent more on health care than any other country suggests that we can find economies in our health care system.

Reducing the level of spending, however, may be easier than altering its rate of increase. I argue that:

1. The enhanced capabilities of medicine have probably accounted for the plurality of the increase over time in real (inflation adjusted) per capita health care costs, although this cannot be rigorously proved.

2. Whatever its cause, the increased health care spending comes at an ever higher opportunity cost; that is, as the non-health care part of the pie shrinks, it becomes ever more painful to shrink it further (shift resources out of the remainder of the economy and into health care).

3. Nonetheless, the key question is how we wish to spend our money, whether on health care or other goods and services, and whether we wish to decide that question through the market, in which case medical spending could continue to rise, or through the political process through some kind of global budgeting. If we try to permanently lower the rate of increase, we will at some point not have the same capabilities we would otherwise have. In the near term, however, one could in principle save money relatively painlessly; whether one could in practice do so is more problematic.

I sketch the argument below; further details are in Newhouse (1992,1993).

The March of Science and the Increase in Health Care Costs

The increase in health care costs is not a new phenomenon. If one looks at real per capita health care spending by decade, one finds that it rose at an annual rate of around 4 percent in every decade except the 1960s, when it rose by 6.5 percent (Exhibit 1). Over the 50 year period, the increase in real per capita spending has been a factor of eight. Because the economy has tended to grow at an annual (real per person) rate of 1 to 2 percent, the share of our resources going to health care has increased to 14 percent and is projected to continue to increase.

I conclude indirectly that new capabilities most likely accounts for the bulk of the cost increase by showing that the commonly mentioned causes of increased spending most likely do not account for much of it, if the capabilities of medicine had remained constant:

Aging of the population. Those over age sixty-five spend about three times as much per person on medical care as do those under age sixty-five, but their share of the population has only grown from about 8 percent in 1950 to 12 percent in 1987. Thus, the increase in the elderly population could account for just a 7 percent rise in medical spending over this period.

The spread of health insurance. The RAND Health Insurance Experiment showed that full insurance resulted in some 40 percent more spending than insurance with a large deductible. It turns out that the change in coverage that induced this 40 percent increase within the Experiment was roughly the same magnitude as the change in insurance coverage nationally over the postwar period. Thus, the spread of insurance alone can account for perhaps only one-tenth of the spending increase.

Increased income. As nations become wealthier, medical spending can be expected to go up even with constant medical capabilities. I estimate that increased income could account for approximately 5 to 25 percent of the increase, but I believe the lower end of this range is more likely.

More physicians. Many people point to the increase in the number of physicians as the cause for increased health spending (i.e., more physicians induce ever more demand for their services, thereby adding to medical bills). We, however, have in effect run a large natural experiment on this point, because we approximately doubled the number of medical students in the late 1960s and early 1970s. This increase had no noticeable effect on the rate of medical care spending; indeed, there appears to be no correlation between the number of physicians and increased spending over the past six decades (Exhibit 2).

More defensive medicine. According to some, a large increase in malpractice claims has induced physicians to perform a

- Second, the costs of health maintenance organizations (HMOs) and fee-for-service plans are rising at a similar rate, so whatever is driving up costs in fee-for-service medicine (e.g., technology) has been driving them up in HMOs as well.

- Third, the rate of increase in the United States in inflation-adjusted medical care costs (using a GDP deflator) is not so different from the rate of increase in other G-7 countries (Exhibit 4).

So Has It Been Worth It?

If one accepts this conclusion, the key question becomes: Have consumers been willing to pay for the costs of these capabilities, or have they mainly been induced to purchase them by excessive health insurance, spawned by the favorable tax treatment of health insurance?

In the traditional American health care market of fully or near fully insured consumers, the test of any medical innovation was whether on average it promised any health benefits, not whether those benefits were commensurate with the cost of the innovation. Consequently, there is a presumption that there might have been too much technology and too much innovation.

We need empirical data to confirm this argument, because it is possible that consumers would have been willing to pay for much of this innovation even if they were weighing the full costs and benefits. Unfortunately, the data are thin, so all I can provide are two indications that suggest that the public heretofore has been willing to pay for much of the increase in medical technology.

- First, if the capabilities of medicine are behind a good bit of the increase everywhere and if countries with very different financing institutions than those in the United States show similar rates of cost increase, they are evidently willing to pay for the technology, albeit not to the same level of intensity. In a nutshell, this may describe what has happened around the world.

- Second, HMOs are the closest thing we have to a market test of willingness to pay for new capabilities, yet in general we have not seen HMOs not offering recent medical advances in exchange for lower premiums. If the explosion in medical care capabilities vastly exceeded consumers' willingness to pay, it seems a little surprising that we have not seen some organization seeking to enter the market without offering all of these capabilities.

Whither Health Care Cost Containment?

A sense that "something must be done" about medical care costs and financing arrangements has developed over the past few years. According to some, that "something" should be managed competition. If managed competition functions exactly as its advocates foresee (a best-case scenario), and it continues to be true that much of the cost increase reflects enhanced medical capabilities that society is mostly willing to pay for, then managed competition will not, apart from a transitory period, slow the rate of increase in

variety of tests and procedures that they would otherwise not perform. Although there is a grain of truth here, defensive medicine, which was pegged at around 3 percent of total spending in 1984, is not an important factor in the overall health spending increase (Reynolds, Rizzo, and Gonzalez, 1987). I nonetheless have elsewhere argued that we can likely greatly improve on the current tort system (Weiler, Newhouse, and Hiatt, 1992).

Administrative costs. Program administration and the net cost of health insurance grew from 4 percent of total spending in 1940 to 6 percent in 1990, so that is clearly not a major source of increased spending (Exhibit 3). We do not have similar data on the administrative cost growth over time in hospital and physician offices, yet even if we did, we could not know to what degree growth in administrative costs has reduced spending that did not justify its benefits.

The terminally ill. Spending on the terminally ill is another prime suspect in the medical care cost mystery. Among the elderly, the 6 percent who die in any one year account for around 30 percent of the expenditures in that year. Yet, it seems unlikely that this is a major factor in the cost increase because (Detsky, et al., 1981, Lubitz and Riley 1993; Newhouse 1993):

- the share spent on people who died, around 30 percent, was stable between 1967 and 1988;
- of those who died in 1978, only 6 percent had more than $15,000 of medical expenses, which does not fit the notion of a great deal of money being thrown at a great many terminally ill patients;
- it is not necessarily obvious before the fact that those who died were certain to die and those who were very expensive were disproportionately those who were predicted to survive.

Productivity in a service industry. In general, productivity is thought to lag in service industries such as medical care, which implies increased prices and increased spending if demand does not commensurately fall, as in health care; Baumol calls this the "cost disease." But ascribing increased medical spending to lagging productivity assumes that productivity in medical care has not changed much over time, which seems obviously true only for long-term and home care -- about 10 percent of the health care sector.

If the various factors listed above do not account for the bulk of the cost increase, what does the large residual represent? Three arguments support my conclusion that the most likely candidate is the enhanced capabilities of medicine.

- First, the factors mentioned above -- more elderly, more insurance, more income -- would raise demand for hospital days and office visits even if technology did not change; however, the rate of patient days and visits is now about where it was in 1960. The great increase in hospital cost has not occurred because more people have been going to the hospital but because they spend more when they arrive.

medical care costs.

Others believe that "something" should be global budgeting. Global budgets that reduced the rate of increase in health care costs would address the rising opportunity costs of health care by freeing resources for other purposes. However, after a transitory period they would threaten ongoing innovation. Moreover, they would probably increase distortions from pricing errors. With tighter budget constraints, I suspect that we may see discrimination against financially undesirable patients and competition for financially desirable patients becoming finer and more sophisticated.

The Health Security Act proposes reducing the real rate of per capita spending to at most zero for the years 1999 and 2000; subsequently health care costs would increase at most at the rate of real GDP (Section 6001).

The issue surrounding the short-term rate of decrease is how rapidly the relatively painless economies can be achieved and how large they are. One indication of the potential for managed competition to reduce costs is what happened to spending on hospitals, physicians, and drugs in the Far West region between 1980 and 1991; in marked contrast to other regions, spending in the Far West decreased 13 percentage points relative to the national average (Exhibit 5). Because the Far West was the region in which price competition was probably most advanced, this is suggestive of the magnitude of the short-term economies that can be achieved (unfortunately, I do not know whether these reductions were concentrated in a few years or were spread rather evenly over the decade). To place this fall in perspective, however, real per capita spending in the Far West still rose by 45 percent over this period (a 3.4% annual rate) (Levit et al., 1993).

Keeping the long-term rate of growth at GDP is an ambitious goal; with the exception of Germany in the 1980s, none of the G-7 countries was able to hold health care costs below the level of GDP growth in the 1960-1990 period, although Japan in the 1980s was close (Exhibit 6). Nonetheless, our percentage of GDP in health is well above other countries, and the ever increasing opportunity cost of resources in health care is likely to force continuing attention to the magnitude of health care spending.

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Exhibit 1

Growth in Real Health Expenditure and GDP, by Decade
(% per Year)

Growth in Real Health $, per capita		Growth in Real GDP per capita	Health Share of GDP at end of period
1929-1940	1.4%	0.0%	4.0%[a]
1940-1950	4.0%	3.1%	4.5%
1950-1960	3.6%	1.5%	5.3%
1960-1970	6.5%	2.5%	7.3%
1970-1980	3.8%	1.7%	9.1%
1980-1990	4.4%	1.7%	12.2%

Sources: Health care expenditure figures: Personal Health Care Expenditure 1929-1950: Health Care Financing Reviews, Summer 1979, Table 3. 1960-1980: Office of National Cost Estimates, "National Health Expenditures, 1988," Health Care Financing Review, Summer 1990, Table 14. 1989: Lazenby and Latsch, "National health Expenditures, 1989," Health Care Financing Review, Winter 1990, Table 13. Deflated by GDP Personal Consumption Expenditure Deflator, Economic Report of the President, 1991, Table B-3. Population: Statistical Abstract, 1990, Table 2, (1929 figure interpolated geometrically between 1925 and 1930). Real GDP from Economic Report of the President, 1991, Table B-2.

[a]1929:3.5%

Exhibit 2

Decade-by-Decade Growth in Numbers of Physicians per Person and Real Spending per Person (Annual Rate of Increase, % Per Year)[a]

Year	Physicians	Spending
1930-1940	0.6	1.4[b]
1940-1950	-0.1	4.0
1950-1960	-0.1	3.6
1960-1970	1.1	6.5
1970-1980	2.4	3.8
1980-1990	2.0	4.4

[a]Source: Health, United States, 1989, Table 85. The figure for 1990 is a projection. 1930 and 1940 figures from Physicians for a Growing America: Report of the Surgeon General's Consultant Group on Medical Education, Frank Bane, Chairman, Table 1. Spending figures from Exhibit 2.

[b]1929-1940.

Exhibit 3

PER CAPITA EXPENDITURE ON HEALTH AND HEALTH ADMINISTRATION, 1990

COUNTY	HEALTH	ADMINISTRATION
Canada	$1770	$23
France	1532	24
Germany	1486	102
U.S.	2566	149

Source: Poullier, 1992, "Some misgivings are felt about the comparability... but the dispersion ...[is not just] statistical vagaries..."

Exhibit 4

G-7 GROWTH RATES OF REAL HEALTH EXPENDITURE PER CAPITA, 1960-1990 (%/YR, GDP DEFLATOR)

	1960-1990	1960-1970	1970-1980	1980-1990
CANADA	4.7%	6.1%	3.7%	4.3%
FRANCE	5.5	7.8	5.3	3.3
GERMANY	4.4	5.6	6.3	1.4
ITALY	6.1	8.9	6.2	3.4
JAPAN	8.2	14.0	7.1	3.7
U.K.	3.7	3.7	4.4	3.1
U.S.	4.8	6.0	4.2	4.4

SOURCE: CALCULATED FROM DATA IN SCHIEBER, POULLIER, GREENWALD, 1992

Exhibit 5
Regional Spending Per Capita on Hospitals,
Physicians, and Drugs as a Percent of
U.S. Spending per Capita, 1980-1991

Region	1980	1991
U.S.	100%	100%
New England	106	113
Mideast	106	112
Great Lakes	100	97
Plains	100	99
Southeast	89	97
Southwest	92	91
Rocky Mountain	82	83
Far West	112	99

Source: Levit et al., 1993

Exhibit 6
Percentage Point Difference in Annual Health Care Cost Growth - Annual GOP Growth, 6-7
1960-1990

	1960-1970	1970-1980	1980-1990
Canada	2.8	0.5	2.5
France	3.5	3.0	1.7
Germany	2.2	3.9	-0.4
Italy	4.1	3.4	1.3
Japan	5.1	4.2	0.1
U.K.	1.5	2.9	0.8
U.S.	3.6	2.5	2.9

Source: Calculated from data in Schieber, Poullier, Greenwald, 1992

Chairman ROSTENKOWSKI. Dr. Simmons.

STATEMENT OF HENRY E. SIMMONS, M.D., PRESIDENT, NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM, ACCOMPANIED BY MARK A. GOLDBERG, DEPUTY DIRECTOR

Dr. SIMMONS. Mr. Chairman, thank you for the opportunity to speak to you about health care reform and specifically the containment of health care costs. With me is Mark Goldberg, our deputy director.

The National Leadership Coalition is the Nation's largest and most diverse group on health care issues. As the list appended to my written testimony indicates, our coalition consists of over a hundred organizations, major businesses and all sorts of industries, unions and the Nation's largest consumer and provider groups. Taken together, these organizations include as employees or individual members about 100 million Americans.

Our coalition is rigorously nonpartisan. Our honorary cochairmen are former Presidents Carter and Ford. We are committed to working as we have been with members of both parties to achieve effective reform.

Congress has a chance now to make history by assuring for the first time that every American will have comprehensive health coverage every day of his or her life, and that is what the debate about health care reform needs to be about; how to make that dream come true and how to make that guarantee real.

That is not all that is at stake in this debate, of course. We know that the costs of health care are eating into our capacity for economic growth, undermining our competitiveness and making it still more difficult for millions of Americans to maintain their standards of living and to afford health insurance. We know as well, although we talk about it less often than we should, that there are serious problems in the quality of much of our medical care. Some of it is the best in the world, but far too much of it falls well short of that ideal. As a physician, it is especially painful for me to have to say that.

Our view is that, to be effective, health care reform has to address all three dimensions of the health care crisis concurrently—cost, quality and access. Thus, for example, an emphasis on cost control alone could exacerbate problems of access and lead to a further deterioration in the quality of care.

The plan that the President has proposed addresses our three critical problems. It would guarantee health coverage to every American. It would reduce the rate at which health care spending increases until it is in closer alignment with overall economic growth; and it would launch an ambitious and needed set of initiatives to improve the quality and consistency of care.

You know that not all the plans in the national debate are designed to meet those standards of performance. Some don't even aspire to the assurance of coverage to everyone.

Some are either less ambitious about the objectives of cost control or are willing to rely on measures that aren't nearly tough enough to meet them. And some attend little, if at all, to concerns about the quality of care.

We commend the administration for proposing a rapid decrease in the rate at which health care costs are climbing. We share the President's conviction that there is enough inefficiency in the current delivery system and therefore enough potential for savings from efficiency gains to make possible this pace of constraint.

We are especially pleased that the administration's proposal includes a provision for rate-setting in the fee-for-service segment, which is to say the dominant segment—the modal segment—of the health care sector. Experience here in the United States and elsewhere in the world has made it absolutely clear that rate-setting is an effective tool for controlling costs and, in the context of a reform strategy that also includes increased competition among health plans, can establish, in effect, a cost ceiling that bounds and yet encourages that competition.

We want to emphasize that in our view cost containment involves, or should involve much more than these tools and stratagems that are most explicitly and apparently designed for that purpose. We want to remind you that cost containment can be served by a variety of other measures as well, such as prevention, increased quality, malpractice reform and administrative simplification, which could indeed save tens of billions of dollars.

We would close our prepared remarks with two additional observations about cost control. The first is that everything else being roughly equal, sooner is better. Frankly, one concern we have about the administration's proposal is that its strategy would not be in place in parts of the country until 1998, which would result in massive cost-shifting to the private sector.

Our closing observation is this: the support for really tough cost control is broader and deeper than commonly recognized. Our coalition is evidence of that, including scores of businesses, large and small, unions, consumer groups, and most of the providers who provide primary care in this country.

We believe that the American economy's vitality is at stake, and we believe that the health of the American people is, too, because unless we are willing to discipline health care spending, it will not be possible to afford to guarantee comprehensive health coverage and excellent care for every American. And we stand ready to speak out for and support aggressive and effective cost containment.

[The prepared statement and attachment follow:]

STATEMENT OF DR. HENRY E. SIMMONS

PRESIDENT OF THE NATIONAL LEADERSHIP COALITION
FOR HEALTH CARE REFORM

BEFORE THE COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

REGARDING HEALTH CARE COST CONTAINMENT

December 16, 1993

I am Dr. Henry E. Simmons, president of the National Leadership Coalition for Health Care Reform. With me is Mark A. Goldberg, the deputy director of the Coalition. We are pleased to have this opportunity to speak with you about health care reform and, specifically, the containment of health care costs.

The National Leadership Coalition is the nation's largest and most diverse alliance on health care issues. As the list appended to my written testimony indicates, the Coalition consists of nearly 100 organizations -- major businesses in all sorts of industries, unions, consumer groups, and associations of health care providers. Taken together, these organizations include -- as employees or individual members -- about 100 million Americans.

The Coalition is absolutely non-partisan. Our honorary co-chairmen are former Presidents Jimmy Carter and Gerald R. Ford. Our co-chairmen are former Iowa Governor Robert D. Ray, a Republican, and former Congressman (and Chairman of the House Subcommittee on Health and the Environment) Paul G. Rogers, a Democrat. We are committed to working, as we have been all along, with members of both parties to achieve effective reform.

Congress has a chance, this year and next, to make history -- by assuring, for the first time, that every American, rich or poor, healthy or ill, will have comprehensive health coverage every day of his or her life. That, at its very core, is what the debate about health care reform needs to be about: how to make that dream come true, how to make that guarantee real.

But that is not all that is at stake in this debate, of course. We know that the costs of health care are eating into our capacity for economic growth, undermining our competitiveness in world markets, and making it still more difficult for millions of Americans to maintain their standards of living and to afford health insurance when they can get it. And we know as well, although we talk about it less often than we should, that the quality of American health care is not all that it should be -- not because some of it isn't the best in the world, but because too much of it falls well short of that ideal.

Our view is that to be effective, health care reform has to address all three of these dimensions of the health care crisis concurrently. Thus, for example, an emphasis on cost control alone -- in particular, on the mechanisms that are most directly associated with cost control -- could exacerbate problems of access and lead to a deterioration in the quality and consistency of care.

The plan that President Clinton has proposed -- and that Mrs. Clinton and others in the Administration have so ably propounded here on Capitol Hill and elsewhere -- would tackle all three of

these issues. By January 1, 1998, it would guarantee health coverage to every American -- actual coverage, not theoretical access to it. It would seek to reduce the rate at which health care spending increases -- until it is more closely in alignment with overall economic growth. And it would launch an ambitious set of initiatives to improve the quality and consistency of care -- and to inform consumers more fully about the care provided by particular institutions and networks, so that they can make better choices.

Not all of the plans in the national debate are designed to meet these standards of performance. Some do not aspire to the assurance of coverage for everyone. Some are either less ambitious about the objectives of cost control or more willing to rely on measures that aren't tough enough to meet them. And some attend little, if at all, to concerns about the quality of care.

We commend the Administration for proposing a rapid decrease in the rate at which health care costs are climbing. We share the conviction of the President and his advisers that there is enough inefficiency in the current delivery system -- and, therefore, enough potential for savings from efficiency gains -- to make possible this pace of constraint. Our own proposal for reform -- released in November, 1991 -- called for a reduction of the rate of growth in health care spending of two percentage points each year until it matches the rate of growth in the gross national product.

We are especially pleased that the Administration's proposal includes a provision for rate-setting in the fee-for-service segment -- which is to say the dominant segment, the modal segment -- of the health care sector. Experience here in the United States and elsewhere in the world has made it absolutely clear that rate-setting is an effective tool for controlling costs -- and, in the context of a reform strategy that also includes increased competition among health plans, can establish in effect a cost ceiling that bounds that competition.

We do want to emphasize that in our view, cost containment involves, or should involve, much more than just the deployment of those tools and stratagems that are most explicitly and apparently designed for that purpose. Cost containment can be served by a variety of other measures that have other rationales as well. Thus, the increased use of preventive care -- which is first and foremost intended to protect the health of patients -- would also help to constrain spending by reducing the need for more expensive acute care. The development of organized delivery systems would increase the capacity of the health care system to monitor and improve the quality and consistency of care; at the same time, these systems would increase the efficiency of the system and reduce administrative overhead. Reductions in the number of unnecessary procedures and technologies, as a result of a greater commitment to outcomes research and the development and promulgation of practice guidelines, would spare patients the risks associated with such unneeded services -- and cut costs as well. Malpractice reform, which would help to reinforce professionalism and reduce anxiety levels in the health care community, would also reduce the incidence of defensive medicine and the costs associated with it. And administrative simplication -- which would make the health care system less baffling and frustrating for patients, providers, and payers alike -- would enable us to save tens of billions of dollars that we spend coping with the extraordinary, and extraordinarily wasteful, complexity of our current system.

We would close our prepared remarks with two additional observations about cost control. The first is that everything else being roughly equal, sooner is better. The longer we wait to contain health care costs, the longer they will continue to rise unabated and the harder they will be to rein in. Frankly, one concern we have about the Clinton administration's proposal is that its strategy for cost containment phases in state by state -- and, as result, will not be in place in many parts of the country until 1998. In the meantime, costs there can continue to rise -- and, as

the rates of growth in Medicare and Medicaid spending are cut back, cost-shifting to private payers in those states would accelerate.

Our closing observation is this: The support for really tough cost control is broader and deeper than is commonly recognized. The National Leadership Coalition includes scores of major businessses, large unions, consumer groups, and associations that represent most the primary-care providers in the country -- all of which support, and stand ready to speak out for, aggressive and effective cost containment. We believe that the long-term vitality of the American economy is stake here. And we believe that the health of the American people is, too -- because unless we are willing to discipline health care spending, it will be difficult, if not impossible, to afford to guarantee comprehensive health coverage, and excellent care, to every American.

MEMBERS OF THE NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

Acme Steel Company
Amalgamated Clothing & Textile Workers Union, AFL-CIO
American Academy of Family Physicians
American Academy of Pediatrics
American Association of Retired Persons
American College of Physicians
American Federation of Teachers, AFL-CIO
American Forest and Paper Association
American Iron & Steel Institute
American Nurses Association, Inc.
American Physical Therapy Association
American Psychological Association
Association of Academic Health Centers
Association of Minority Health Professional Schools
B. C. Enterprises
Banc One Corporation
Bank South Corporation
Bethlehem Steel Corporation
Blue Diamond Growers
Brown & Cole Stores
Burlington Coat Factory
Caterpillar Inc.
Ceridian Corporation
Christian Children's Fund
Chrysler Corporation
Cold Finished Steel Bar Institute
Communication Workers of America
CoreStates Financial Corp.
Cox Enterprises Inc.
Crown American Corporation
Del Monte Foods
Drummond Company Inc.
Families USA Foundation
Filter Materials
First Interstate Bancorp
Ford Motor Company
Georgia-Pacific Corporation
Giant Food Inc.
The Great Atlantic & Pacific Tea Company, Inc.
Gross Electric Inc.
The Heights Group
H. J. Heinz Co.
Geo. A. Hormel & Company
Hunt-Wesson Inc.
Inland Steel Company
INSIGHT Treatment Services, Inc.
International Brotherhood of Electrical Workers
International Multifoods
International Union of Bricklayers and Allied Craftsmen
James River Corporation
Johnstown Corporation
Keebler Company
Keller Glass Company
Lincoln Telephone & Telegraph Co.

Lockheed Corporation
LTV Steel Company
Lukens Inc.
Maternity Center Association
National Association of Childbearing Centers
National Association of State Boards of Education
National Easter Seal Society
National Education Association
National Steel Corporation
Norwest Corporation
Olympia West Plaza, Inc.
Pacific Gas & Electric
PAR Associates
Pella Corporation
Preferred Benefits
R. R. Donnelley & Sons Co.
Ralphs Grocery Company
Regis Corporation
Rohm & Haas Company
Safeway Inc.
Sara Lee Corporation
Scott Paper Co.
Service Employees International Union, AFL-CIO
Sokolov Strategic Alliance
Southern California Edison Company
Strategic Marketing Information, Inc.
Texas Heart Institute
Time Warner Inc.
United Air Lines, Inc.
United Food and Commercial Workers International Union, AFL-CIO
United Paperworkers International Union, AFL-CIO
United States Catholic Conference
United Steelworkers of America, AFL-CIO
UNUM Life Insurance Company of America
U.S. Bancorp
The Vons Companies, Inc.
Westinghouse Electric Corporation
Wheat, First Securities, Inc.
Wheeling-Pittsburgh Steel Corp.
The Whitman Group
Wisconsin Public Service Corporation
Xerox Corporation

December 7, 1993

Chairman ROSTENKOWSKI. Thank you. Mr. Winters.

STATEMENT OF ROBERT C. WINTERS, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, PRUDENTIAL INSURANCE COMPANY OF AMERICA, ON BEHALF OF THE BUSINESS ROUNDTABLE

Mr. WINTERS. Thank you, Mr. Chairman, members of the committee. My name is Robert Winters. I am chairman and chief executive officer of the Prudential Insurance Company of America, but I come before you today on behalf of the Business Roundtable, an association of some 200 chief executives of leading U.S. corporations, some corporations of which are represented in the coalition to which Dr. Simmons refers.

I am pleased to offer the Business Roundtable's thoughts on the daunting problem of health care reform, but I want to note that the roundtable is in the process of revising its formal health reform position and we ask permission to include that position in the hearing record at a later date.

Chairman ROSTENKOWSKI. Without objection, so ordered.

[The information follows:]

The Business Roundtable supports the enactment of comprehensive health care reform in 1994. We believe that the enactment of health care reform requires development of a bipartisan consensus. We do not support the administration's proposal.

As a starting point for health care reform, the Roundtable supports the Cooper-Grandy/Breaux-Durenberger legislation because they best build upon the strengths of our current system, contain needed insurance reform, expand coverage to low-income persons not now covered, but avoid unnecessary governmental regulation and new off-budget entitlement programs. Further work is needed on certain cost shifting and tax provisions. Tax treatment of health care costs should encourage consumers to make quality, cost effective health care choices while respecting income tax principles that employer costs remain fully deductible.

We want to achieve health care reform this year. We want to get away from the inefficiencies that plague the system, reduce the cost-shifting and make affordable, quality health care available to all Americans. We are committed to the process and will continue to discuss ways to achieve reform with the White House, the Congress and all interested parties.

Mr. WINTERS. Thank you.

The Business Roundtable CEOs have learned about health care the hard way. A decade ago we realized that medical inflation was zapping our vitality and threatening our ability to create or maintain jobs for our people. Faced with either the choice between decline or change, most American corporations chose change.

We began buying our employees' health care more efficiently. We used our size to demand better rates. We insisted that providers perform only procedures that were medically necessary.

In short, we gave our strong support to what has become known as "managed care." Today more than 90 million Americans receive their health care from managed care and that is 8 times the level of just 10 years ago.

The reason is simple. Managed care systems such as health maintenance organizations offer the best and perhaps the only chance to bring costs under control and preserve quality. Using managed care, we have rewritten the rules of health care economics and I am sure Dr. Reinhardt gave you some interesting views on those rules yesterday.

For the first time, however, purchasers of health care have the power to drive down costs, while insisting on top quality care.

Today, managed care plans on average cost $700 per employee less than traditional fee-for-service plans, while maintaining high quality.

A new survey shows that the rate of increase for HMO plans, for instance, will decline in 1994 for the fifth year in a row, declining to 5.6 percent from 8.1 percent in the previous year; and that is half the rate of increase estimated for traditional fee-for-service plans.

And in some highly competitive markets, HMOs are actually reducing, reducing the cost of premiums even as the level of patient satisfaction rises. That increase in satisfaction indicates that managed care is not skimping on quality. To the contrary, managed care providers are spending enormous efforts to improve quality, because one of the lessons we all know in business is that mistakes cost money. This revolution in health care is occurring all over the United States.

We are proud of the role the business community has played in bringing market-based economics to bear. We would hope that Washington would speed up the positive change that is already occurring in the marketplace.

The President came before the Congress 3 months ago and challenged you to put in place bold health care reform. The Business Roundtable strongly applauds that sentiment. The question becomes, what is bold health care reform?

The Roundtable would argue that placing more power in the hands of consumers is truly bold. Letting the market sort out the most efficient providers of care reveals courage and confidence. Looking at H.R. 3600, the Roundtable finds a number of bold proposals which will help to restructure the market.

Reforming the insurance market to eliminate cherry-picking and job-lock is a long needed step. So is rewarding consumers for making wise health care choices. And the commitment to measure quality is critical to developing a market-based health reform system.

In short, this bill has some good incentives and the right intentions. Unfortunately, when it came time to decide how to regulate this new system, those who developed the bill apparently weren't willing to trust market forces. Rather than choosing the cleansing principle of the market, they opted for the belief that government knows best.

Throughout history, governments have frequently sought to tame unruly economies by instituting price controls. Premium caps based on the CPI, is H.R. 3600's method.

We all know the record of price controls. They have never worked, and I believe Dr. Wilensky will testify further to that effect. The law of unintended consequences is even more serious in restructuring health care than in previous attempts at price control.

Managed care networks need capital to expand and to provide quality care. The premium caps will freeze that capital flow. The price caps in H.R. 3600 will undermine the development of the new delivery system the bill would create.

We also have to question why this bill has put such power into the hands of these huge, heavily-regulated, government-controlled health alliances. The Employee Benefits Institute has estimated

that 99 percent of employers and at least 70 percent of employees would fall into these alliances and that does not sound like competition to us.

Large employers have led the way in innovation and in rewriting the rules of health care economics. H.R. 3600 discourages this kind of progress, and if you have doubts about how this plan might stifle creativity and innovation, I would recommend to you testimony that Michael Peel of General Mills presented on the Senate side.

He made it clear that General Mills, one of the innovative purchasers of health care in the United States, would probably drop out altogether and simply turn a check over to the government to take care of their employees.

Another concern of ours is that the mandate on small business will end up restricting new jobs and curbing growth, leading to lower tax revenues and potentially higher deficits or taxes.

Several months ago Robert Samuelson wrote in the Washington Post, "just because the present system is flawed doesn't mean we can't make it worse." Having government, in effect, take over one-seventh of the U.S. economy, would in our view make it worse. It would reverse the positive changes now occurring in the market and stifle the innovation and investment we need to transform our delivery system.

We think that there are a lot of things that government can and should do, but we are concerned that this legislation goes too far. We should let the market do the policing. That is the most effective way that health care reform is going to work. For the first time in memory, health care consumers are on the advance. We are gaining ground. As the Hippocratic oath says, please "do no harm." Give us a chance.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF ROBERT C. WINTERS
CHAIRMAN AND CHIEF EXECUTIVE OFFICER
THE PRUDENTIAL INSURANCE COMPANY OF AMERICA
REPRESENTING THE BUSINESS ROUNDTABLE
BEFORE THE COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
DECEMBER 16, 1993

Thank You, Mr. Chairman and Members of the Committee. I am Bob Winters, Chairman and Chief Executive Officer of The Prudential Insurance Company of America. I come before you today on behalf of the Business Roundtable, an association of 200 chief executives of leading U.S. corporations with approximately 10 million employees.

I am pleased to offer the Business Roundtable's thoughts on the daunting problem of health care reform. But I want to note that the Business Roundtable is in the process of developing a formal health reform position and we ask permission to include that position in the hearing record at a later date.

The Business Roundtable CEOs have learned about health care the hard way. A decade ago we discovered that medical inflation was sapping our profits and threatening our growth.

Faced with decline or change, most of corporate America changed. We began buying our employees' health care more efficiently. We demanded that we receive better rates because of our large numbers. We insisted that providers only do procedures that are medically necessary. In short, we gave our strong support to what has become known as "managed care."

Today more than 90 million Americans receive their health care from managed care -- that's eight times the level of just 10 years ago.

The reason is simple. Managed care systems such as health maintenance organizations offer the best -- perhaps the only -- chance to bring costs under control and preserve quality.

Using managed care, we have rewritten the rules of health care economics. For the first time purchasers of health care have the power to drive down costs while insisting on top quality care.

For example, managed care plans on average now cost $700 less per employee than traditional fee-for-service plans. A new survey shows the <u>rate</u> of premium increase for HMO plans, for instance, will decline in 1994 for the fifth year in a row, to about 5.6 percent. That's half the estimated rate of increase for traditional fee-for-service plans.

And in some highly competitive markets, HMOs are actually reducing -- that's right -- reducing the cost of premiums even as the level of patient satisfaction rises.

That increase in satisfaction indicates managed care is not skimping on quality. To the contrary, managed care providers are spending enormous effort to improve quality because, as all of us in business have learned, mistakes cost money.

This revolution in health care is occurring all over America. We are proud of the role the business community has played in bringing market-based economics to bear.

And we look to Washington to speed up the positive change that is already occurring in the marketplace.

Three months ago the President came before Congress and challenged you to put in place bold health care reform. The Business Roundtable strongly applauds that sentiment.

The question becomes -- what is bold health care reform? The Business Roundtable would argue that placing more power in the hands of consumers is truly bold. Letting the market sort out the most efficient providers of care reveals courage and confidence.

Looking at H.R. 3600, the Business Roundtable finds a number of bold proposals which will help to restructure the market.

Reforming the insurance market to eliminate cherry-picking and job lock is a long-needed step. So is rewarding consumers for making wise health care choices. And the commitment to measure quality is critical to developing a market-based health reform system.

In short, this bill has some good incentives and the right intentions.

But, unfortunately, when it came time to decide how to regulate this new system, those who developed this bill apparently lost their way. Rather than choosing the cleansing discipline of the market, they opted for the tired belief that "government knows best."

Throughout history governments have frequently sought to tame unruly economies by instituting price controls. Premium caps based on the CPI is H.R. 3600's method.

You all know the record of price controls. They have never worked. Very often they lead to higher prices when people learn how to game the system. They certainly undermine any attempt to get rid of inefficiency. To give one example, when Medicare froze physician fees between 1984 and 1986, physician expenditures rose nearly 30 percent and the volume of services dramatically increased, with the greatest increase being in high cost surgical specialties for discretionary procedures.

The law of unintended consequences is even more serious in this circumstance. Managed care networks need capital to expand and provide decent quality care. But premium caps will freeze that capital flow. The price caps in H.R. 3600 will sow the seeds of destruction for the new delivery system the bill would create.

We also have to question why this bill has put such power into the hands of these huge, heavily-regulated, government-controlled health alliances. It is estimated that 99 percent of employers and at least 71 percent of employees (some say 80 to 90 percent) would fall into these alliances. That doesn't sound like competition to me. Virtual monopolies are anti-competitive.

What's really ironic is that the alliance scheme punishes the group that has been most effective in reducing health care increases -- large employers.

If you have any doubts about how this plan will stifle creativity and innovation, I urge you to read the testimony of Michael Peel, Senior Vice President of General Mills, who testified before the Senate Labor and Human Resources Committee two months ago.

General Mills is one of the nation's most innovative purchasers of health care. In fact, this year the company showed an actual decline in per capita health care expenses -- not a decline in the rate of increase, a real decline -- thanks in part to prevention programs they run for their employees.

Mr. Peel testified that should H.R. 3600 pass, General Mills would probably not form its own corporate alliance. He stated that the new taxes and new regulation, as well as the potential cost shifting from the health alliance to his company, would just be too much to bear. Instead, this innovative company would stop managing its employees health care and just write a check to the government.

It's sad, but I don't think General Mills would be alone. Many innovative companies who have led the way toward market-based reform will throw up their hands in frustration if H.R.3600 becomes law. State alliances will replace concerned employers, mandates will replace incentives, and creativity and innovation will be left to the new bureaucracies, not an inspiring thought.

H.R. 3600 runs another risk -- its financing. The Business Roundtable asks: given the state of the budget deficit, does it really seem wise to take on another entitlement program, especially one which is off budget?

We have not yet seen how the Administration arrived at its numbers. But when talking about new entitlements and subsidies, isn't it only right to expect the actual numbers to be higher than the government's estimate? Remember, in 1965 President Johnson told us Medicare hospital costs would run about $9 billion in 1990. The actual cost was $67 billion. And we are still looking for the budget surpluses which were to accrue after the 1981 tax cuts.

Another worry is that the mandate on small business will end up restricting new jobs and curbing growth, leading to lower tax revenues and potentially higher deficits or taxes.

Obviously, we would like to see everyone brought into the system. Everyone should have access to decent care and, frankly, the cost-shifting is hurting us badly. But we believe restructuring the delivery system is a challenging and necessary first step. Let's do that right before we consider mandates.

Several months ago Robert Samuelson wrote in the Washington Post: "Just because the present system is flawed doesn't mean we can't make it worse."

Having the government in effect take over one-seventh of the U.S. economy would certainly make it worse. It would reverse the positive changes now occurring in the market and stifle the innovation and investment we need to transform our delivery system.

There is a role for government to play.

Government can make the market function more efficiently by enacting insurance market reform, eliminating cost shifting, creating purchasing pools for small businesses, removing state anti-managed care laws, designing quality assessment standards, funding outcomes research and instituting significant tort reform.

The Business Roundtable stands ready to work with you to enact this program.

But let the market do the policing. That's the most efficient way, that's the only way health reform is going to work.

For the first time in memory, health care consumers are on the advance. We're gaining ground. As the Hippocratic Oath says, "Do no harm." Give us a chance.

Thank you, and I would be glad to answer your questions.

Chairman ROSTENKOWSKI. Mr. Meyer.

STATEMENT OF JACK A. MEYER, PH.D., PRESIDENT, NEW DIRECTIONS FOR POLICY

Mr. MEYER. Thank you, Mr. Chairman.

I would like to illustrate my first point by telling a little story about my dog, Clemenceau. Now, my dog likes to go outside and play around in the yard, but when he reaches the edge of the property, he bumps up against what is known as an "invisible" or "electronic" fence. He gets a little shock and has to come back. But he is allowed to roam the whole yard as long as he stays within the boundaries.

I am afraid that the budget caps proposed by the Clinton plan are the equivalent of moving my dog's invisible fence right up to the door of my house. The boundaries are drawn so tightly that my poor little dog Clemenceau doesn't have a chance to roam around in the yard at all.

I do understand the need to have a little shocker out there if the market incentives included in the Clinton plan don't do their job. And the administration makes the case quite forcefully that it is good to let the market work, and just in case we are wrong, there is this backup system of shocks.

The problem is, I think they have drawn the controls so tightly that the backup system won't let the market incentives work. Let me illustrate what I mean.

A research study just released estimated that insurance premiums per person would be, on average, $5,975 in 1998. This study also estimated that if the Clinton caps were in effect, there would be only $4,268 available to pay those premiums, or some 28 percent less than the authors' estimate of what the premiums would be.

Now I believe there is some waste and inefficiency in the system, but I don't think you want to impose that kind of a severe cut just as the little dog opens the door. That is my first point: Allow the market to work, put in a little breathing room; and put more money into the plan at the front end to assure that cost-effective health plans can survive, expand and invest.

We need to make investments in information technology, in primary care physicians, and in capital improvements in order to make a managed competition system work. So, give health plans a little slack to do this.

My second recommendation is to relax the severity of the proposed deceleration in allowable annual increases in Medicare and Medicaid spending, as well as private sector spending.

Again, if you are going to have a cap—and I am not here commenting on whether to do it but how to do it—if you are going to go that route, you need to have a little breathing room. When I see a program like Medicaid that has been growing well in excess of 20 percent per year for the last few years, being brought down to 4 percent by the end of the decade, that is one tough cost constraint.

And I don't believe that these kinds of decelerations can be achieved entirely by cutting payments to providers without affecting access and quality. I think they will end up affecting the consumer.

So, my second recommendation is to relax the severity of the caps if you are going to use them.

My third recommendation is, if you are going to have a managed competition model, which I favor, then for goodness sake, don't leave out the linchpin of that model, which is a ceiling on the amount of employer contributions to health insurance that employees may exclude from their taxable income. The Clinton plan virtually leaves this out or puts it in such a diminished form that it is hardly recognizable.

If you are going to make consumers cost conscious about their choice of health plans, the way to do it is to impose a tax on their selection of a higher cost plan. And by the way, such a tax would generate a substantial amount of revenues, certainly in excess of $20 billion a year, which could go a long way toward paying the cost of covering our neediest citizens.

And that brings me to my final point, which is that because the Clinton plan doesn't raise this revenue, and because it doesn't target benefits very well to those most in need, it ends up having to cut Medicare and Medicaid so much to make ends meet that I fear it will be a dreadful situation for the recipients of those programs.

If you targeted programs more to those in need, you wouldn't have to make such deep cuts.

Let me give you just one small example: retiree health benefits. The Clinton plan would essentially buy out corporate obligations to provide these benefits for early retirees, regardless of income. I think it would be better to target that benefit and perhaps a few others like it to those people with lower incomes.

And so in closing, I would say that if we put a little more money in the Clinton plan at the front end, if we relax the deceleration built into spending caps, if we put much more reliance on market forces and let them breathe and include a tax cap which would do that, and if we scale back some of the subsidies in the plan, targeting them to those in need, I think you would have a plan that was both more realistic and more equitably financed. Such a plan could then compete better, I think, with the other alternatives on the table.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JACK A. MEYER
PRESIDENT
NEW DIRECTIONS FOR POLICY

The theme of my testimony is that there has been too much argument over whether the arithmetic underpinning President Clinton's cost controls is correct, and too little debate over whether the controls are appropriate. There has been too much discussion of whether the goals are achievable, and an insufficient debate over whether the targets laid out in this plan are desirable.

I am in fundamental agreement with the goals of President Clinton's health care reform plan. I am particularly pleased that the administration is committed to achieving universal insurance coverage, and welcome its endorsement of a managed competition framework for improving the cost-effectiveness and fairness of the health care system. I am concerned, however, about some of the specific cost control measures included in the President's plan, as well as some of the measures excluded from the program.

I have been asked to focus my testimony on the budget caps incorporated into the Clinton plan. How realistic are these caps, and what are their potential side effects? This testimony will not address the question of whether government-imposed spending limits are a good idea in the first place, but rather focus on this question: given the desire on the part of the administration to use spending caps in combination with, and as a backup to, a managed competition model, are the budget caps developed by the administration workable and appropriate?

The Controls Are Too Tight

My first observation about the controls incorporated in the Clinton plan is that they are very tight and restrictive. This can be seen as either a strength or a weakness of the plan, depending on your point of view. According to one notion, controls should be launched as very tight limits, and then relaxed, if absolutely necessary, at a later date, to accommodate public demands. A different view is that controls should start out with some built-in slack, and tightened later if necessary.

In my view, the Clinton plan needs to move from the first concept to the second because of its desire to blend controls with a managed competition framework. There is much debate about whether any form of budget controls will stifle competitive reforms. I want to focus on a different, less theoretical issue -- are these specific controls compatible with managed competition? The more taut the controls, the less the breathing room for the development of the managed care networks upon which competitive reforms rely.

Let's start with the initial levels of allowable spending. The figures put forward by the administration as the average cost of premiums -- $4,200 for a family plan and $1,800 for individual coverage -- seem too low. Data from the Health Insurance Association of America indicate that the average cost of a family plan in 1991 was a little over $5,000. How, then, can a reform plan launched three to five years later provide coverage for about 16 percent less than what insurance cost in 1991?

To be sure, the Clinton plan hopes to move people into managed care networks resembling group and staff model HMOs, and there will be some associated cost savings. But HMO family premiums averaged $4,680 in 1991, still nearly $500 above the starting point for the Clinton plan. Moreover, people will not switch plans overnight, the savings from HMOs are not enormous, and as a broader mix of Americans enroll in HMOs, their costs may rise.

A study just released by the firm Lewin-VHI projects that premiums for couples without children and two-parent families will average $5,464 and $5,975 in 1998. (Premiums for individuals and one-parent families were projected to be $2,732 and $5,172, respectively.) The Lewin-VHI study found that these levels exceed those used by the Clinton administration by 17 percent.

I am not saying the administration's figures are "wrong." I have not reviewed their methodology, and I am certain they made a good-faith effort to estimate the cost of their plan accurately. I am saying that the numbers seem very optimistic, and the savings implied by them are not likely to emerge from true efficiencies. Rather, this plan seems to imply a regulatory crunch at the outset, as the amount of money put into the system initially is well below what the system is costing today. The edict would be, "Here is 83 cents on the dollar to start with (or whatever the number actually is), make it stretch." While there are some efficiencies that could be realized early on (e.g., economies of scale from risk pooling through alliances), there are also some start-up costs. This could become a game of musical chairs -- when the music stops, someone will not have a seat.

Having commented on the adequacy of initial funding, the next step is to review the allowable cost increases over time. The administration's plan calls for reducing Medicare annual spending increases from 11.6 percent in 1994 to 4.1 percent in 2000. This would occur in a program that Congress just cut by $56 billion, and has cut several other times in recent years. And yet no basic structural reforms are proposed for Medicare, either in the area of incentives for managed care or relating beneficiary contributions to income. The plan proposes to cut the annual increase in Medicaid, which has averaged over 20 percent in recent years, from 16.5 percent in 1994 to 4.1 percent in 2000. Private sector increases would be brought down from 7.4 percent to 3.5 percent over this period.

Again, the theme of my remarks is that the issue is not whether the Clinton numbers are right or wrong, or whether they are achievable. I have no reason to believe the administration's math is wrong, and in theory at least, these cost constraints are achievable. Indeed, it is worth noting that many other countries have achieved the type of budget control implied by the plan's scenario for reducing the gap between health care spending and overall inflation, and basic measures of their health outcomes are equal or superior to ours.

The question is not can we do this -- we can. The questions are do we want to do it, do we want to do it this quickly, what will be the benefits of doing it, and what are the costs?

The Benefits and Costs of Budget Control

First, let me comment on the benefits of bringing health care spending increases down to the growth of the economy, or the inflation rate, or some similar tough target, in a few years time. This achievement would release hundreds of billions of dollars in resources to be spent on areas of unmet need and national priority -- including education, environmental protection, law enforcement, and infrastructure. It would increase workers' take home pay, which has been badly squeezed by rising health care costs. And it would help reduce the federal government's deficit while also releasing some of the intense fiscal pressure on state and local government. These are important benefits, and not to be taken lightly.

Yet, the resources released for these valuable uses have to come from somewhere. They will be pulled out of the health care sector, with a mixture of results. Some of the cutbacks in health care spending growth will reflect reductions in waste and inefficiency -- no loss there. Some will reflect lower incomes for medical professionals and related personnel, and job losses (these losses, of course, will be offset to a large degree by job gains in the sectors toward which the released resources flow). And some will reflect a slowdown in the development and diffusion of technology, and limits on access to advanced medical technology.

This last set of effects is worthy of careful consideration. It may not occur in the first year, or even the first few years -- the waste and inefficiency in our system gives us some room for maneuver with limited sacrifice. But with constraints as tight as those proposed in this plan, it will not be too many years until real and significant give-ups occur.

What is needed now is an honest debate about whether the very real and important benefits associated with closing the gap between health care spending increases and gains in broader measures of economic activity are worth the likely sacrifices in health care innovation and access that will flow from the type of major reallocation of resources envisioned by the Clinton plan. Simply put, are the benefits worth the cost?

We will not be well served by reassurances that we can meet these targets by ending waste, fraud, and abuse. We've heard that many times over the years in the case of getting the federal budget under control, and found it wanting. We will not get health care or the federal budget under control unless we are all willing to do without some things we seem to want.

Competing proposals offered by Representative Cooper, Representative Michel, and Senator Chafee would rationalize incentives and let market forces determine how much of our resources are allocated to health care. At least over the next few years, these plans would be likely to make only a minor dent in the growth curve of health care spending. There will still be tradeoffs under these plans, as consumers devote more and more dollars to health care that could be redeployed to other uses. But such tradeoffs are less discernible than when budget controls are used, and spending is directed away from health care under explicit government formulas.

This means that these competing proposals will offer us much less in the way of both the benefits described here and the sacrifices within the health care needed to get them. Less gain, less pain. It is worth remembering, though, that if we let health care spending continue to grow as a share of our economy, we will be sacrificing wage gains and investments to meet needs outside the health care sector.

I am not one, then, who believes that these two types of proposals are more alike than different. They are alike on the relatively easy questions, most of which involve how to distribute our national health care spending more fairly -- how to reduce the unconscionable inequities among Americans, based on income and health status. We need to do this, of course, and the major plans all propose it to a greater or lesser degree.

Similarly, all agree that we need to measure outcomes, profile providers, and contract selectively based on cost and quality. All agree that we should reform our malpractice system, reduce paperwork, and take other steps that will reduce inefficiencies.

But the key issue that divides us today is not how to slice the health care pie fairly. Nor is it how to capture some technical efficiencies. Rather, it is how rapidly that pie will grow. Here the philosophical split could not be more clear. One group of proposals says that the market shall determine this. The Clinton plan says that government will set the limit, asserting (somewhat too optimistically) that the market forces it too includes (in more limited form) will probably keep us from hitting the caps.

I would like to raise the possibility of an intermediate position. Is there any room between a position of no caps, and the extremely tight caps proposed by President Clinton?

Because I believe in the managed competition approach, I don't want to see it smothered by excessively tight controls. This is not just a philosophical argument. If controls are too tight, we will not have the capital to invest in the infrastructure of managed competition -- the primary care doctors, the physical expansion of HMOs and other types of alternative delivery and financing systems, the information systems, etc. For this infrastructure to develop, health plans need payment rates adequate to cover these costs on top of basic service costs.

Yet, I also recognize that the market forces I believe in will take considerable time to play out, and may only take us so far in controlling the long-run growth of health care spending. This may occur because the health care market is somewhat different from many other markets, and because people want health care technology if it has even a remote

chance of helping them, and they want it now, not later. Faced with good and rational incentives, people may still say that they want all the new stuff that medical science can deliver. They may say, "Yes, I see the cost more clearly now with your new incentives, but yes, I'd still like to ante up and get what I want."

Before rushing to either polar position on controls, we may want to explore an intermediate position. This would include three important changes in the current Clinton plan. First, the plan would put more money in at the front end, so that competitive forces are not stymied. Providers and health plans have to be able to breathe to compete! Second, the plan could use targets for allowable annual increases in expenditures, and these targets would not be legally enforceable in the early years. The targets would be backed up by formal controls held in reserve. Third, the targets could be set with somewhat more slack in them than is found in President Clinton's proposed premium controls and government spending limits.

For example, might it be worth starting with a target that is three percentage points above inflation plus a population factor, instead of one and a half percentage points, as used in the Clinton plan? Then the "excess" over inflation could be brought down over six years in equal increments of one-half of a percentage point.

In addition, the Clinton plan could bolster its effort to foster managed competition by incorporating the most central feature of an incentives-based approach -- a ceiling on open-ended tax subsidies. A limit should be placed now -- not in the next decade -- on the amount of employer contributions to health care that employees may exclude from taxable income. If you're serious about competition, this linchpin of the competitive model cannot be omitted or included as a faint shadow of its real self.

With a "tax cap" in place, the administration might not have to so heavily regulate health plans. Corporate alliances, for example, could be given more leeway than under the current plan. The size-of-firm threshold for opting out of regional alliances could be substantially lowered. Fee-for-service plans might not have to be "offered" in a straight jacket. Let the private sector innovate and compete, and make sure that consumers pay the extra cost if they select a high-cost plan. But change the playing field to force competition based on price and quality, not on side-stepping high-risk consumers.

The administration may also want to consider scaling back some of the new government subsidies in its plan and targeting them more to real financial need. For example, it makes no sense for government to pick up 80 percent of the cost of health care for those retiring before the age of 65, regardless of their incomes, especially when these retirees have employer-sponsored retiree health benefits. Instead of offering a taxpayer buyout of corporate obligations, the plan should assist those retirees without insurance coverage who cannot afford premiums because of low incomes.

Similarly, the plan's proposed subsidies for small firms with lower-wage workers takes a good idea too far, and is very costly. The size of these subsidies overstates the negative side effects of an employer mandate.

If the subsidies in the Clinton plan were more tightly targeted to financial need, and a cap were placed on currently open-ended tax subsidies, the pressure on the government's budget under this plan would be greatly reduced. This would obviate the need to decelerate Medicare and Medicaid outlay increases so drastically. This means that the financing of the Clinton plan would be much more equitable. By slashing Medicare and Medicaid subsidies, most of which go to lower-income Americans, and then redeploying this money to open-ended subsidies not well targeted to financial need, the Clinton plan would be robbing Peter to pay Paul. Indeed, we may find that in many cases Paul has a higher income than Peter!

In conclusion, if a policy mix is chosen that combines budget caps and managed competition, I recommend building more slack and room for maneuver into such caps than currently exists in the proposed Clinton plan. Including a real "tax cap" would also help the

plan by stimulating the type of movement into well-managed health care networks that the administration seeks. This step would also raise revenues to help finance new benefits. If such a step is coupled with an effort to target new government spending to financial need, Medicare and Medicaid spending cuts, compared to baseline, could be relaxed. This step, coupled with a corresponding relaxation of premium caps, would provide the "degrees of freedom" needed to foster the development of a managed competition system.

In summary, the Clinton plan could be improved by the following changes:

- Put more money into the plan at the front-end to assure that cost-effective health plans can survive, expand, and invest in the basic infrastructure of a managed competition model.
- Relax the severity of the deceleration in the allowable annual increases in Medicare and Medicaid spending, as well as private health care spending.
- Place a ceiling on the amount of employer contributions to health care that employees may exclude from taxable income.
- Target new subsidies more carefully to financial need.

Chairman ROSTENKOWSKI. Thank you, Mr. Meyer.
Dr. Wilensky.

STATEMENT OF GAIL R. WILENSKY, PH.D., SENIOR FELLOW, PROJECT HOPE

Ms. WILENSKY. Thank you, Mr. Chairman. My name is Gail Wilensky. I am a senior fellow at Project HOPE. I am delighted to be back before you again. I am speaking only for myself and not for the foundation where I work.

I would like to briefly discuss some of the proposals for reducing spending on Medicare and Medicaid, and if I have time, to make a few comments on the premium cap and spending limits, as well.

The administration has proposed a reduction of $124 billion in Medicare spending over 5 years, from fiscal years 1996 to 2000. This is about the amount that Medicare was spending as a program the last year that I was administrator in 1992.

This reduction comes in addition to the $56 billion of saving that was included in the economic plan that was passed by the Congress in August of 1993. So what we are talking about is $180 billion coming out of Medicare in the decade of the 1990s, far more than has ever either been proposed or implemented.

The reductions involve more than 25 specific payment changes. The majority of them, although not all of the savings represent reductions in provider payments. My concern when you reduce the hospital update factor, reimbursement for capital, reimbursement for outpatient services, et cetera, all of these provider payments, is that this is a strategy that penalizes the efficient, conservatively practicing practitioners, as much as it penalizes the aggressive practitioners. It does nothing to attack volume, which is the most serious problem that we have in Medicare, and does little to improve the incentives associated with Medicare.

This strategy exacerbates the perverse incentives of Medicare itself which rewards aggressively practicing physicians and hurts conservatively practicing ones.

There are some proposed changes that I find much less objectionable, because they are either designed to change incentives, such as changing the coinsurance rates on laboratories or home health, or because they reduce disproportionate-share spending, which would no longer be justified with the universal coverage that has been proposed.

I see this primary reliance on reductions in provider payments as being of some questionable judgment politically, although I will leave that to you. There is a practical problem, however, and that is that these reductions are being used to finance the expansions of two new benefits to the elderly. So if they don't occur, it will require either changing the benefits that have been promised, prescription drug and home care, or finding new acceptable sources of revenue.

But more importantly, I am concerned about the policy implications of the reductions. In the first place, it exacerbates the incentive problem that I just mentioned, where the most aggressive physicians and practitioners are rewarded. But the second problem is that it will hit certain hospitals very hard.

Medicare-dependent hospitals, rural hospitals, unless they happen to have a lot of uninsured people living right around them, are going to get hit very hard and will have trouble surviving.

A third problem that concerns me is that this policy stresses the schism between the incentives of a price-controlled Medicare system, that is, increasing volume, and the incentives of providers who are part of managed care, which is what we believe will be the dominant form of health care for the nonelderly, which is to decrease volume.

So this means you will have practitioners facing exactly opposite incentives. Be careful on volume, cut out the less necessary utilization, or increase volume if it is in any way appropriate. This is likely to produce some very confused practitioners of health care.

My fourth concern has to do with the philosophy that is reflected in this type of cost containment. That is, taking the same program, the same benefits, plus some, for the same population, with the same incentive structure, and thinking that you can take out $180 billion and not do any damage. It is not going to happen and it is not a very wise way to try and reduce spending.

There are all sorts of ways to get money out of Medicare if you are willing to make fundamental changes in the design of the program. But if you want to stay primarily with provider payment reductions, then you are going to have to settle for much more modest reductions.

I have substantially fewer concerns about Medicaid. For the most part these savings reflect reductions in disproportionate share-spending, which would no longer be justified under a system of universal coverage.

I am concerned that cost shifting has been institutionalized with the savings associated with Medicaid. This happens, as I know you have heard, because health alliances will get 95 percent of what Medicaid has been spending for the cash assistance population, trended forward, and will only have this amount to cover whatever health package former Medicaid recipients choose from the health alliance. But there is no way that this amount will cover the cost of a health care package. This means that private sector people who are in the same health alliance will end up picking up the share of the bill that Medicaid isn't paying.

It's peculiar. This is an administration that has talked so much about eliminating cost-shifting and then absolutely builds it into the new system.

And finally, let me say a couple of words about spending limits and premium caps. We are hearing a lot of talk about market forces, but I agree, as both Mr. Newhouse and Mr. Meyer have said, that what has happened is that limits have been proposed that are so tight that it will effectively dominate anything that goes on within the private sector.

The increases they have assumed are far less than we have seen in other industrialized countries, and we need to understand that when you talk about spending limits and premium caps that are this tight, the limits and caps are what will rule.

Premium caps are just another name for price controls. Our history as a country is very consistent when it comes to price controls.

We keep them in place for a short time, and then blow them up, usually followed by a surge of inflation.

So our history suggests that these price controls won't work very well. And you better be careful if this is the heart of your cost containment strategy.

As with Medicare, the administration has made spending limits and premium caps an integral part of their plan. They are using them as protection against charges of cost-shifting in Medicare. They are also using premium caps as the rationale for increased personal income receipts, which is supposed to occur because employers will spend less on health insurance, and therefore, give their employees more in wages which will mean more in the way of taxable income.

I personally doubt that CBO is going to score it quite that way, but that will be clearer next month when CBO presents its estimates. But it means that if you move away from premium caps and spending limits you will have to make many other changes. The plan is so complex and so tightly integrated, that if you move away from some of the controls or regulating structures you will also have to modify the benefits promised or the mix of public and private sector financing. You not only need to consider whether the plan will really contain spending as promised, and I obviously have some questions about this, but if you don't accept all of the changes for whatever reason, you will have to modify the benefits promised as well.

A lot has been promised. In my opinion, too much to too many. And I think that modifying these promises will be a problem.

Thank you.

[The prepared statement follows:]

TESTIMONY OF GAIL R. WILENSKY
SENIOR FELLOW
PROJECT HOPE

Thank you, Mr. Chairman, for inviting me to testify. My name is Gail R. Wilensky, and I am Senior Fellow at Project HOPE. Project HOPE is an international health foundation, but I am not here as its representative; the views that I am expressing are my own. I am pleased to have this opportunity to appear before you again.

Health care spending and cost containment issues have been a concern of Washington and this committee for many years. With the proposal for universal coverage that is contained in the President's health care plan, H.R. 3600, the issue of cost-containment takes on an even greater urgency than it has previously. I commend the Chairman for holding this hearing, as one of many on health care reform, so that the Administration's proposals for cost-containment can be examined in greater detail.

The issues that I would like to discuss are the Administration's proposals for reducing spending in Medicare and Medicaid, as well as the use of a premium cap and spending limits as strategies to control private sector spending.

Medicare Reductions

The Administration proposes a reduction of $124 billion in Medicare spending over the five year period, FY 1996-2000. This is approximately equal to the spending on Medicare during my last year as HCFA Administrator, in 1992. The $124 billion reduction is in addition to the $56 billion dollars of savings that was included in the Economic Plan passed by the Congress in August of 1993. This means that the Administration is proposing over $180 billion in reductions to Medicare projected spending levels within the decade of the 1990's, an amount far exceeding any amount previously proposed or implemented.

The Medicare reductions involve more than 25 specific payment changes. The majority of them represent reductions in provider payments. The payment changes include reductions in the hospital update factor and in Medicare payments for hospitals, which together provide over $28 billion in savings, changes in hospital outpatient department payments and changes in physician reimbursement under medicare, which account for more than $26 billion in savings, reductions in payments for durable medical equipment of almost $10 billion, and several smaller items of reduction as well.

The emphasis on provider payments reductions, both in the current proposal as well as the Economic Plan, has led some to characterize the Administration as engaging in a "slash and burn" approach to providers. It is a strategy that penalizes the efficient, conservatively practicing practitioners as much as it penalizes aggressive practitioners, does nothing to attack volume, the most serious problem in Medicare, and does little to improve the incentives associated with Medicare. In fact, it will exacerbate the perverse incentives of Medicare that reward the more aggressive practicing physicians and hurt the more conservatively practicing physicians.

Some of the other reductions to Medicare that have been proposed are more easily justified, either as a part of health care reform or because they will produce greater efficiency in the operation of the program. For example, changing the co-insurance for home health agencies, or establishing a co-insurance rate on laboratories not only raise revenue but may also produce savings by lowering utilization. Reducing payments for disproportionate share hospitals and for indirect medical education, can be justified on the grounds that a significant portion of payments in these areas cover the costs of treating the uninsured and would no longer be needed in a program promising universal coverage.

The predominant reliance on reductions in provider payments as a

cost-containment strategy in the health care reform package and in the Medicare savings included in the Economic Plan is of questionable wisdom substantively, and appears to this non-politician, as politically unlikely as well. The political wisdom of these changes will ultimately be decided by the Congress, but the practical problem is that the benefits that have been promised the elderly -- prescription drug and home care -- are being financed by these spending reductions. If they are rejected or substantially reduced , comparable reductions will need to be made in the benefits unless new, more acceptable funding sources can be devised.

My greater concern, however, has to do with the policy implications of these reductions. The Administration is attempting to control Medicare spending primarily by reducing provider payments, which has several undesirable attributes, in addition to the perverse incentives discussed earlier. First, the sharp payment reductions to hospitals will hit certain types of hospitals very hard, forcing at least some serving the Medicare population to close. All hospitals treating substantial numbers of Medicare beneficiaries would have fewer funds for medical supplies, testing and equipment compared to current service levels. Rural hospitals, with their low occupancy and relatively high Medicare populations and "Medicare-dependent" hospitals, with their high concentrations of elderly, will have a difficult time surviving . Second, these payment reductions will further stress the schism between a price controlled Medicare system, where providers can attempt to compensate for low payments by volume increases, and a managed care oriented system for the non-elderly, where providers respond to risk-based provisions by limiting less necessary utilization. Whether this clash in incentives affects the availability and accessibility of services to the elderly will probably depend on the dominant practice orientation of the physician, i.e., whether most of the physician's patients are Medicare or non -Medicare managed care. My third area of concern has to do with the philosophy that is reflected in this type of cost containment strategy for Medicare. Nominally, Medicare remains the same program, promising the same benefits (plus some), serving the same population under the same incentive structure, but with $180 billion taken out of its spending growth. It will not be the program it has been, and the elderly had better understand that beforehand. There is certainly substantial potential for reducing Medicare spending, but to do it wisely will require changing the incentives, or the benefit structure or the population covered by the program or setting more modest reduction targets in spending levels.

Medicaid Reductions

The Administration has proposed spending reductions of $65 billion for Medicaid. Because the size of the reduction is so much less and the philosophy underlying the cost containment strategies implied by the Medicaid changes is so different, I am far less concerned about these proposed reductions than I am about the Medicare reductions.

The disproportionate share payment program, which has been a major source of Medicaid spending growth, will be eliminated and in its place there will be a small reserve of funding for hospitals treating large numbers of low income people. Basically eliminating disproportionate share spending is reasonable since the justification for the disproportionate share spending program is to finance the cost of serving large numbers of low income uninsured individuals, which will no longer be an issue under a program of universal coverage. Of course, disproportionate share monies could be provided to the states to fund care for the uninsured even without a program of universal coverage.

The remaining Medicaid reductions are more problematic, although the philosophy underlying the change is easier to justify. Individuals who have been on cash assistance programs and thus

eligible for Medicaid will obtain their health care from the regional health alliances. The health alliances will receive 95% of the average cost of Medicaid per capita as payment for their care. While the former Medicaid population will probably find itself in managed care settings, which contain their own incentives for cost containment, the funding for the former Medicaid population will exacerbate problems of cost-shifting. The policy presumes that health care alliances will be able to provide services to the Medicaid population comparable to the services provided to private payers with funding at 95% of what would have been paid under Medicaid. It may be possible to do this in a few states, but it will not be possible in many others. If this amount is less than the cost of the health care plan, which it will be frequently, the residual will be shifted to private sector participants, with the increases in their premiums reflecting what will become institutionalized underpayment for the Medicaid population.

Spending Limits and Premium Caps

The Administration says it is relying on market forces to contain spending in the private sector, but just to "make sure," it has also introduced premium caps and spending limits. As is frequently the case with controlled systems, the growth rate built into these spending limits, and thus the growth in the premium caps that will produce the desired spending limit, is very stringent. After a three year phase-in, growth rates in the private sector will be limited to CPI plus population. To understand how stringent this is, it is useful to consider the experiences of some of the Organization of Economic Cooperation and Development (OECD) countries. According to the OECD figures for the years 1985 - 1991, for example, German health care expenditures grew annually at 2.9% above inflation, the Canadian single payer system grew annually at 4.8% above inflation, and the British nationalized system grew annually at 4.1% above inflation. With an annual population growth projected at less than 1%, the Administration would allow health expenditures to grow at less than 1% per year after the year 2000, after adjusting for inflation. This is a rate none of the industrialized countries have been able to achieve -- even with global budgets, administered pricing, and a tight control on technology.

What will happen is that rather than be dominated by market forces, private sector spending will be determined by the caps, with the ceilings becoming floors and competition occurring only for factors other than price. Our experience with price controls in World War II and the 1970's, administered pricing under DRG's and RBRVS and with administered prices in rate setting states indicates that although there always could be price competition below the preset level, it just doesn't happen. Furthermore, our history with price controls is that they are short lived and unsuccessful.

But it will be very difficult for the Administration to remove the premium caps and spending limits from their legislation. Despite our experience with price controls, many members of Congress remain convinced that spending will only be moderated by regulated pricing and spending limits. In addition, private sector spending caps allow the Administration to avoid at least some charges of cost shifting to the private sector. Even with the more moderate spending reductions of Medicare in the past, the private sector has charged that these reductions have been shifted to them. Cost shifting would be a much more serious issue, given the very large reductions being proposed, and particularly when these reductions do not reduce costs or change any of the incentives in the Medicare program. The use of private sector spending caps also allows the Administration to promise a predictable level of cost containment for the private sector, and to serve as a crucial link in the rationale that allows them to claim billions of dollars in added personal income tax collection. The logic underpinning the latter claim is that

because health care costs will be limited in the private sector by premium caps, employers will increase wages faster than they otherwise would have, resulting in an increase in taxable earnings. Whether employers would actually increase taxable incomes or increase other forms of tax-sheltered income, such as other fringe benefits, and how much tax receipts might decline from people pushed out of the health care sector is another matter, and will undoubtedly be scrutinized by the Congressional Budget Office.

Conclusion

The Administration's cost-containment strategy in Medicare is dominated by payment reductions to providers. Benefits are being expanded to the same Medicare population, and there is no change fundamentally in the incentives facing either Medicare beneficiaries or the physicians and hospitals providing services to them. What is being proposed, therefore, is a Medicare program that provides the same acute care benefits to the elderly, who have little reason to be concerned about costs (since 80% have Medicare plus some other form of supplementary insurance) and who are being provided services by physicians who are predominantly practicing fee-for-service medicine. Since there is no incentive to change behavior or reduce costs under such a strategy, cost-containment, to the extent it occurs, will primarily reflect the effects of the regulatory strategy. The dominant strategy for cost containment in Medicaid is to pay the health alliance only 95% of what previously had been paid by Medicaid and have the alliance figure out how to finance any remaining costs.

The dominant cost containment strategy in the private sector involves the use of spending limits and premium caps. The Administration claims to rely on market forces, but the use of premium caps and spending limits will overwhelm the market. Ceilings become floors and any competition that occurs will be on a non-price basis. Furthermore, the Administration has proposed a variety of mechanisms that obscures and shields consumers from the true cost of health care, such as the use of employer mandates, unlimited tax subsidies from employer provided insurance, community rating of premiums, and subsidies to low wage firms, all of which undermine the effects of market forces. Perhaps the past will not be a prologue for the future, but the experience of the United States with price controls is that they are unsuccessful, other than in the very short term. Having premium caps that are tied to increases in spending limits which assume lower rates of spending growth than has occurred in any of the industrialized countries makes their use seem even less promising. Altogether, not a very likely combination for success.

Chairman ROSTENKOWSKI. Let me ask you generally, is it possible to control health care costs without also providing universal coverage? Or do these two things go hand-in-hand?

Ms. WILENSKY. Well, providing universal coverage will mean that some people who have been out of the system are going to increase their use of health care. We need to understand that.

It is not that the uninsured haven't used any health care, but every indication we have is that they use systematically less health care and will use more if they have coverage. So if we only have universal coverage and we do everything the same as we do now, we will spend more money.

There are a lot of aspects about our current system that make us spend money that probably aren't very wise: The hassle and expense of a lot of different forms, malpractice concerns, perverse incentives for physicians and hospitals and bad incentives for consumers and for the purchasers of health care. Purchasers don't know what they are buying, and tax laws encourage them to buy more than they would otherwise.

If you try to control spending with heavy duty regulation that has no escape valve, which I don't believe as a country we usually do, you could control spending. Alternatively, which I would prefer, you could change incentives, make purchasers more cost conscious about what they are buying, have them push hard the providers and make sure that the rules in place are being followed. Either of these changes would allow you to bring in the uninsured and also lower the spending rates we have been experiencing. But this would take several years to play. In the near term, covering the uninsured will increase spending.

Dr. SIMMONS. Mr. Chairman, in answer to your question—can you have cost containment without universal access? We think absolutely not, because otherwise you can contain costs purely by not giving care. And the fascinating thing to us is that even the theorists who developed the managed competition model insist that the sine qua non for that to work is that you have to have universal access.

They went further and said that it should be built on an employer mandate. But we think absolutely you cannot ethically or realistically control costs unless you have universal access. And that is why we say we have to have concurrent action in the areas of access, cost and quality if we are going to fix this problem.

Mr. WINTERS. We would offer the observation that what H.R. 3600 represents is a new and by far the largest entitlement program we have ever seen, and it is off budget. We do not believe that an off-budget entitlement program holds nearly as much hope for containing the costs of health care in this country as private market forces do.

We were told in 1965 that Medicare hospital costs for 1990 would be $9 billion. They were $67 billion.

Chairman ROSTENKOWSKI. Thank you.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. It is interesting. The panel would like the profit-making entrepreneurs to run this system. Dr. Meyer worries, I think, that we draw the controls too tightly, although Dr. Simmons says that he supports really tough

cost control and aggressive cost containment. I am inclined to agree with him.

Mr. Winters says that we should let the market do the policing. That is the most efficient way for this, the cleansing discipline of the market. I would like to just take an example from our current industry, from the largest, most highly regarded health insurance company in the country, and look back at their record, go back 7 years when they copped a plea on securities fraud.

Now, they agreed to voluntarily comply, I guess using the cleansing discipline of the market, so over the past 7 years they seem to have ignored that because they systematically misled hundreds of thousands of investors or customers and defrauded them of about $8 billion.

They lied to them about the risk, they lied to them about the return on investment. The company itself was inadequately managed. They abused the clients' trust. They paid illegal bonuses, perhaps even bribes to salespeople to perpetuate this fraud.

And when they were caught by customers and called to task, they lied about the damage done. So just a couple of months ago, in October of 1993, they agreed to cop the plea, in effect, and pay $370 million in penalties.

Well, but lo and behold, this month, just a couple of weeks ago, we found that in December of this year a company executive exposed phony appraisals made by this company to increase the fees it received as trustee, and what does the company do? They fired the one honest executive we have been able to identify in this charade, and he had an industry-wide reputation for integrity.

Now, with this record from one of the best and biggest in the industry, in light of what seemed to be obviously lax and inadequate regulation and supervision of the insurance industry, how could this committee consider turning over the management of our families' health care to an industry with this lack of regulation?

Wouldn't we need extensive regulatory laws mandating probably felony penalties for executives, mandating unlimited personal liability for directors and executives before we delegate our responsibility to an industry represented by such a tawdry record?

Now, if you believe they will change their spots, recently in written testimony before another committee of the House this same company stated its intention to deny poor people full and equal access to all of their medical facilities. They subsequently told another member of this committee they changed their policy. Yet today, in the State of Maryland, Medicaid beneficiaries who sign up with this company are denied access to the highest quality care in that company's plans which they offer to rich people.

Now, I am not sure these are policies that this committee can foster. And I think actually, Mr. Winters, your statement saying we should let the market sort out the most efficient providers of care requires courage and confidence may be the understatement of the century.

Thank you, Mr. Chairman.

Mr. WINTERS. Mr. Chairman, while I am here on behalf of the Roundtable, if I may respond to some of the specifics, I have some knowledge of the situation to which Mr. Stark refers.

The company in question makes no bones about having had in its employ people who made mistakes. Companies who employ large numbers of people can never avoid this, although they can strive, as that company has and does, to avoid it or to minimize it.

Insofar as the securities sold, there was nowhere near 8 billion dollars' worth of loss. The company has agreed, and has consistently agreed that it will refund or make whole people to whom these sales were misrepresented. But we have never pretended that every investment we sell will increase in value and we do not pretend that today.

Insofar as the real estate evaluation issue is concerned, the individual who filed the suit was not fired. He is still in that company's employ, at the same salary and benefits that he had before. In connection with—I am only partly familiar with the Maryland situation, but there has been misunderstanding about the provision of medical care for the urban poor.

We run in the city of Baltimore, Md., a very effective clinic. About two-thirds of the clinic population is private sector employees and one-third are Medicaid beneficiaries. They receive exactly the same care. It is a very high quality of care and they receive it at less cost to the Medicaid program than the average of the city of Baltimore.

One of the challenges of managed care is to be sure that physicians are well-qualified to do the work which they undertake. That is a commitment of the plans of the company to which you refer.

One of the issues in Medicaid inner city populations is that they present challenges with which some physicians are not familiar. For example, a pediatrician whose practice is entirely suburban is unlikely routinely to make lead poisoning tests. Yet he or she must remember to do that if looking at an inner city child.

It is common to prescribe medications which require refrigeration. It doesn't occur to most doctors that many inner city families don't have refrigerators and that you have to provide a refrigerator, which the Baltimore plan does, in addition to the medication, if that is what is required.

The objective is to have physicians who are well-qualified to treat the patients whom they will be serving.

Mr. CARDIN. Mr. Chairman, may I ask unanimous consent that Mr. Winters or I be permitted to follow in the record any additional information in regards to this matter?

Chairman ROSTENKOWSKI. If there is no objection, certainly.

[No additional information was received.]

Chairman ROSTENKOWSKI. Mr. Thomas.

Mr. THOMAS. Thank you, Mr. Chairman.

Were I to use the same technique that my colleague from California used in describing the House of Representatives, taking the worst of any particular individual and attributing it to the whole, I think he would react in much the same way you and the gentleman from Maryland, Mr. Cardin, reacted. That is a familiar technique.

Mr. Winters, what really concerns me in your testimony is what you have told me regarding the senior vice president of General Mills—a company known pretty much as an innovative company in

general. I have had some involvement in some other areas with them and they have an excellent program. As a matter of fact in their analysis of the plan, they would not opt out for the corporate alliance and pay the penalty. They would stay inside the system.

I have heard this over and over again from most of the major corporations. This bothers me a lot that organizations who should be going their own way under the structure are not. What it tells me is, as one of my southern colleagues said, inside this plan it appears there is too much sugar for a dime; that is, there are too many benefits available for people who don't opt out of the system.

Dr. Simmons, you indicated that cost control, all things being equal, is what we should strive for, and sooner is better. I have not heard most people say that we really can pay for everything under the Clinton plan basically through squeezing out waste, fraud and abuse, and a little tobacco tax on top of that. If we are going to try to go to universal coverage, doesn't it make sense that that is our primary goal?

My direct question to you is that I noticed a member of your coalition is the Ford Motor Co., and that they yesterday testified that they thought the Clinton plan was a great idea.

Do you have any knowledge at all to what extent they might think it is a good idea because of the incentives built into the plan for large companies in terms of early retirement on top of all of the other sugar babies that are in the plan? Does it not make a lot of sense for Ford Motor Co. to be in favor of that plan for what they are going to get picked up by the Clinton administration?

At the same time, it was interesting that PepsiCo was against the plan because they have a lot of service-oriented folk who aren't locked into big, heavy, fringe benefit plans that would be picked up by the government?

Dr. SIMMONS. Is that the end of your question?

Mr. THOMAS. I want to know why some companies are opting for it.

Dr. SIMMONS. OK. Let me answer your comment on our first observation, where we said we think that sooner is better and that we ought to be ambitious about the cost controls, by making a couple of observations.

Our own proposal was released in 1991 and this is from a coalition, by the way, of very conservative people, by and large, including huge parts of corporate America. We thought very carefully first about what kind of constraint it would be reasonable to put on the system economically to bring it back into some kind of fighting trim where it would be worth paying what we pay for.

And we noted several observations. First of all——

Mr. THOMAS. I have only 5 minutes. And so rather than look at a plan that isn't on the table, let me ask you the direct question again.

Is it so important to get down on costs and universal coverage that your coalition would be willing to support paring back some of the added new benefits like the early retirement portion of the program? Is that something that you think should go first if we don't have enough money to do everything?

Dr. SIMMONS. Well, possibly. We believe, however, that we do.

Mr. THOMAS. Possibly? What does that mean as an answer?

Dr. SIMMONS. Just that, just that. We believe that you can, in fact, control the costs as proposed both in the President's plan and ours, and I would remind the committee that we would still be spending twice as much as any other Nation in the world and still be spending 17 percent of our gross national product. That is a huge amount of money.

Mr. THOMAS. Here is my problem, Dr. Simmons. The First Lady said it in front of this committee. They have got these enormous new benefits and a potential reduction in saving.

I said "Wouldn't it be better if you tie the new benefits to the real savings"? She said no, in essence.

Now, my problem is I have every belief that this Congress will vote the benefits. I have no confidence whatsoever we can match the spending timetable that would be necessary to pay for the benefits.

Not just the universal coverage, not just the expanded medical benefits for Medicare, but the sweeteners inducing large corporations, like early retirement, to get onboard the program, as well. I am sorry, but most responsible people who have testified in front of this committee do not believe that waste, fraud and abuse reduction, and a tobacco tax, will pay for the enormous new costs that are present in this program.

Dr. SIMMONS. Mr. Thomas, just to be sure the record is clear, our coalition would not endorse a program that didn't address concurrently all three of those critical issues, cost, quality and access, and contain within it an adequate financing strategy so that we could in fact assure health security for America.

Mr. THOMAS. Then are you opposed to the President's plan.

Dr. SIMMONS. I did not say that at all.

Mr. THOMAS. By the criteria you just established for support, you are in fact opposed to the current plan.

Chairman ROSTENKOWSKI. Mr. Cardin.

Mr. CARDIN. Thank you, Mr. Chairman.

Let me followup on this just for a moment because I do think it is somewhat disappointing, particularly many of the people in our business community, their shock at us trying to bring the cost of health care down to a growth rate equal to the growth rate of our economy, adjusted for the demographic changes, plus some more percentages.

So the Clinton proposal on trying to control health care costs characterized as very ambitious will bring the growth rate down from a very, very high level to a high level. Yet the same people who suggest that these targets are unrealistic have no qualms about recommending to the Congress that we have a hard freeze on our space program or a hard freeze on our transportation program or a hard freeze on our housing program or a hard freeze on every other government program, but for some reason health care is in a different category and it is very disappointing to me to see people who have been on the forefront in trying to get fiscal accountability for some reason think that health care is exempt from that type of budget discipline in trying to make very difficult decisions.

I would hope that we would learn from the last panel that indicates that if we fail in achieving health care cost containment, if

we are not successful, there will continue to be an erosion of the reimbursements under Medicare by the Federal Government. We cannot allow that entitlement program to grow.

We are going to have to bring it down. And all that is going to mean is that the private sector, those people that have private insurance, those employers and employees are going to pay more.

So I would think that the Roundtable and the other business groups would be more sensitive to trying to develop ways of bringing down cost. Now you say that managed competition will do it, the market force will also do it.

But Dr. Newhouse has given us every reason in the world why that won't work because there is legitimate reasons for costs going up, as there are legitimate reasons to spend money in every category of spending.

So I guess my comment or question is, why do you believe, those that are advocating the competition approach, that we are going to succeed in the private marketplace without budget discipline, without some form of a budget target, when you can point to no other nation in the world that has been able to do that and no real experience other than perhaps a small, contained group where that has worked?

But a health care system that spends over $900 billion a year, why all of a sudden is the market forces going to work, when Dr. Newhouse has explained to us the many various, legitimate reasons that will be given year after year why we have to spend more and more and more?

Mr. WINTERS. The Roundtable is not suggesting that an entitlement program, and whether on or off budget, but perhaps particularly if off budget, can be contained without some kind of cost controls. What we are urging is don't start with the entitlement program.

Mr. CARDIN. What I am suggesting is why not start, as the President has, with the budget target as to how much money we can spend? We can argue as to how it is enforced, how much Federal regulation or State regulation or private sector involvement is involved. That is a legitimate concern that you are raising. And we are going to debate that.

But how do you justify coming to this table and health care reform without a target as to what we must accomplish on bringing down health care costs?

Mr. WINTERS. The Roundtable thinks it makes a lot of sense to have national expenditure targets.

Mr. CARDIN. Enforced?

Mr. WINTERS. Initially, we should start with national health care targets with the appropriate adjustments of the kind the previous panel was discussing, adjusting for the increasing age of our population, probably adjusting in some fashion for technology, although that is debatable. We believe that the first thing to do, is to set targets and then if we miss them, try to understand why, and fix what is wrong.

Dr. SIMMONS. Mr. Cardin, if I could respond to that also. We share your concern that if we put all our faith in managed care or as some would wish, in managed competition, that it could prove extremely serious for us, and I would remind you that just last

month you had prepared for this committee the GAO report that basically concluded that little empirical evidence exists on the cost savings of managed care.

And that happens to be a true statement. What little evidence does exist is on staff and group model HMOs, but only 5 percent of the Nation is enrolled in those. So we think it would be a disaster to rely on a strategy with that little evidence, though clearly we have to figure out some way to get better competition in the system.

What fascinates us is that the providers themselves are telling us, hundreds of thousands of physicians and nurses are telling us, we need economic discipline on the system. Otherwise it is not going to become efficient and we are not going to fix the quality problem. That is a telling statement.

Ms. WILENSKY. I would like to comment, also. I think the changes in the Medicare program that are being proposed don't make a lot of sense. We've had trouble controlling spending in Medicaid. Two major new benefits are being proposed. Reductions are being proposed that exceed anything that this committee or the Congress has been willing to seriously consider or implement in the past. The real problem is that you are trying to hold back spending with no changes in incentives, primarily relying on reductions in provider payments for savings and using these savings to fund new benefits.

But the point that you are raising in the private sector is a legitimate question. Does this country want to turn to expenditure targets and price controls? Because there is no sense having a spending target unless you have an implementing mechanism, and the only implementing mechanism for a spending target is price controls.

If this country wishes to go that direction, that is a perfectly legitimate position for society to take but the administration isn't posing the choice this way.

They are wrapping themselves in the cover of the free market—the market's going to make the changes, but they are not allowing markets to work. This is a very serious issue for the country to consider. If the majority of the Congress, if the American people believe that we should control health care spending by spending limits as they do in many industrialized countries, then fine.

If they don't, then they are going to have to look seriously in other directions. What I have objected to is talking like you believe in market forces, when in fact you are setting up an extremely top-down regulatory system.

Decide which way you want to go. You can only go one way or the other, and do it. If you are really serious about regulations, truly serious, I believe you can control spending through a regulatory system. In the past, this country hasn't been willing to implement sufficient controls and I have doubts that we are willing now.

But you got to go one way or the other and do it seriously. But let's be honest what we are proposing.

Mr. MEYER. I would like to add to your question, sir, that it is very interesting what the Clinton plan left out in trying to control a program like Medicare. They left out relating the payments that

beneficiaries make to their ability to pay, except for couples making over $130,000 and individuals with incomes over $105,000, which is a very small number of people.

Perhaps one of the ways we are going to have to get the Medicare program under control is going to our Nation's senior citizens and saying your part B premium is going to have to vary a little with your ability to pay. It won't be popular.

Another thing the Clinton plan has left out is incentives to move the Medicare population into the type of managed care that they think is so important for the nonMedicare population. I am not saying managed care works magic, but the plan has relied almost exclusively on slashing payments to providers, which can't help but affect consumers.

I don't think any of us want to have a double standard, and say we will be easy about Medicare and Medicaid when we will be tough about other things. We may even have to take the radical step in this country someday, not really so radical, of making the eligibility age for Medicare 67, like Congress has already done for Social Security in the next century. These are tough calls.

Without these kinds of tough calls, Medicare is going to go broke in some years, you all know that. You have stewardship over it.

But I really think that to say that people who have some questions about the Clinton cuts aren't concerned about controlling the Medicare program doesn't——

Mr. CARDIN. All that does is who pays the bill, not whether the bill is going up.

Mr. MEYER. Well, I am not so sure, especially on the managed competition piece.

Chairman ROSTENKOWSKI. Mr. Kleczka.

Mr. KLECZKA. Thank you, Mr. Chairman. I agree with the sentiments of my colleague from Maryland. In fact, I can just see the groups that you folks represent coming to the Congress in the spring insisting when we put together the deficit reduction bill that we cut entitlements and trim back on Federal spending.

But today I am hearing from Mr. Winters and Mr. Meyer, that, my god, what are you doing to Medicare, Medicaid. You can't be slashing these entitlement programs. And then in the next statement indicate that under the Clinton plan it is a new entitlement. I think we are hearing some mixed messages.

Although, Gail, I agree with you that based on what we did to Medicare in the spring, what is called for in this legislation might not be obtainable. So I think your caution about the amount of cuts is well-taken, and I think it is of concern to the committee.

But, Mr. Winters, under your plan, you indicate managed care all of a sudden is now working. We haven't heard this in past years, until the President's plan was introduced.

Now, all of a sudden, the current market is okey-dokey and doing fine. But let's say you are correct and managed care is doing fine.

How would you encompass in your idea universal coverage and portability of health care plans for your workers and other American workers? Or are they inconsistent?

Mr. WINTERS. No, I testified that we believe, for example, that job-lock and cherry-picking are wrong and they need to be elimi-

nated; and that is the kind of role which the government can appropriately play.

Mr. KLECZKA. OK. The cherry-picking I think is universally agreed to. That we can get at.

Now, how do we provide universal coverage and portability?

Mr. WINTERS. Well, obviously we would like to see everyone brought into the system. Cost-shifting, cost-shifting from employees, companies which do not provide health care benefits, is hurting Roundtable member companies. And we believe that everybody should have access to care, access to affordable——

Mr. KLECZKA. See, that was Pepsi's argument yesterday. They provide a very high level of benefits for the beverage department, but in their other sundry investments, and I think they mentioned Pizza Hut, they indicated that 71 percent of their employees have health plans through a spouse being paid for by larger corporations.

And they like that. So we don't have to tamper with that, that was OK. Well, sure that is OK, somebody else is paying the bill. But give us the answer. How do we make sure that the other working spouse receives coverage with the company that he or she is with?

Mr. WINTERS. Well, we do not support mandates at this point. We believe that everyone should have access to affordable——

Mr. KLECZKA. Should we send Pizza Hut a letter saying would you please do this, and if they answer no, tough? See, there has got to be some mechanism to ensure that the other employer provides coverage or the universal coverage and portability do not exist.

Mr. WINTERS. We believe—I am not familiar with the Pepsi-Cola, PepsiCo testimony.

Mr. KLECZKA. It was a hoot.

Mr. WINTERS. I am sorry?

Mr. KLECZKA. It was a hoot.

Mr. WINTERS. Judging from what you say, our answer would be the employees of Pizza Hut should have available to them affordable health care protection.

Mr. KLECZKA. Should Pizza Hut be asked to pay a part of that?

Mr. WINTERS. We do not believe that mandating employer coverage, mandating employer participation——

Mr. KLECZKA. OK. So give me the answer to how a $5 per hour Pizza Hut employee can go and buy insurance on the private market.

Mr. WINTERS. The purchase should be subsidized and in the case of $5 an hour, probably totally subsidized by the Federal Government.

Mr. KLECZKA. Another entitlement?

Mr. WINTERS. No, another opportunity—another incentive to take care of themselves; not to compel them to.

Mr. KLECZKA. Where do you suggest the Federal Government get the dollars to provide for that new incentive?

Mr. WINTERS. I think, as Gail and others have pointed out, extending access to health care to more Americans, as we should, is going to cost us money. When it is clearer how much extension we are doing, how much money is involved, then we have to grapple,

and obviously this committee has to grapple with the issue of how do we fund it.

Mr. KLECZKA. Do you have any ideas? Can you give us a little hand here?

Mr. WINTERS. At this point, our concern is that you contain the amount that is required.

Mr. KLECZKA. No, but you just said we should have universal coverage, bring the other people in, knowing it is going to cost more.

Mr. WINTERS. I said we should have universal access. Everyone should have health care available to them.

Mr. KLECZKA. OK. But that will cost more.

Mr. WINTERS. I am sorry?

Mr. KLECZKA. But that will cost more.

Mr. WINTERS. Any system which extends the health care significantly is going to cost more.

Mr. KLECZKA. You have no recommendations how to pay for that?

Mr. WINTERS. Not at this point.

Mr. KLECZKA. OK.

Dr. SIMMONS. Mr. Kleczka, we would, however, make a point. We would disagree that any system that extends more coverage will automatically cost more. If you really have systemic reform, with all the things that that entails, including economic discipline, we are convinced you will have a system that ultimately is less expensive. And we would not subscribe to the notion that assuring everyone coverage will cost more than the present system is going to force us to pay.

Ms. WILENSKY. In the short run it will cost you more. There is no way it is not going to cost you more in the short run.

Mr. MEYER. I wouldn't want to leave the impression that the administration's plan, which relies on an employer mandate, doesn't involve expenditures of Federal money. Recall that the administration has earmarked $169 billion of Federal money between 1994 and 2000 to offset the cost of the mandate for small employers.

The alternative approach is contained in Congressman Cooper's bill and Senator Chafee's bill among others. This involves directly subsidizing the individual instead of imposing a head tax on the employer. There is money involved either way.

Mr. KLECZKA. You are familiar with Cooper. How does Cooper pay for that?

Mr. MEYER. He pays for it, in part, through the reduction in disproportionate share payments, and, in part, by capping the tax deduction which employers may take on their employee health contributions.

I am concerned about whether there is enough money in there in the long run to pay for it.

Mr. KLECZKA. I don't think it does.

Mr. MEYER. But I would advocate paying for it using a ceiling on the amount that employees can exclude from their taxable income. You may need some excise taxes in addition.

The point is we will have to pay more if we want to cover these people, either way. The real question is, is it going to come from the budget of a small firm—and ultimately the firm's workers—or

is it going to come from the budget of the Federal Government, and therefore, taxpayers at large? There are some fairness questions here.

Mr. KLECZKA. Well, currently it is on the budget of the Federal Government and on the budget of the large corporations of America. And I don't——

Mr. MEYER. And only about half——

Mr. KLECZKA. I don't think it is inequitable to ask a small business to pay a subsidized contribution.

Ms. WILENSKY. But it is not the businesses that pay. You keep saying the businesses.

I think that you heard often enough that an employer mandate is a way to force employees of those companies to use their compensation to buy insurance.

It is not like it comes out of the employer's pocket. And it is why people have said rather than go through the indirect route of trying not to hurt either new small firms, who may have trouble getting from the point where they are not providing insurance to the point where their low wage employees who will be forking out a lot of their compensation to buy insurance, perhaps you should look to individual markets. At least this way you can subsidize those individuals who need help because they are low income but not subsidize individuals who have $100,000. The value of the tax exclusion is getting serious again because of the increase in marginal tax rates.

For a while, we had almost a proportional subsidy, but we now are back in the position where we not only have an open-ended subsidy, but the level of the subsidy is absolutely perverse. The higher your income, the more you get as a subsidy from the Federal Government when your employer provides health insurance. But in any case, it's not the employer that's paying.

Mr. KLECZKA. No, we have seen the growth in real wages over the past years suffer because of that. I will stipulate to that for sure.

Thank you, Mr. Chairman.

Ms. WILENSKY. That is why focusing on individuals is something that you might want to seriously consider. You will need to decide whether or not ultimately you think it is politically or practically feasible, but it certainly gets you out of some of the problems you are now into like $160 billion subsidy to undo potential job loss that may result from an employer mandate.

Mr. KLECZKA. But to give it to the individual we are going to have to go back to the corporation, ask for some kind of assessment, probably based on payroll.

Ms. WILENSKY. You are going to have do something to make sure this money gets back to the employee.

Mr. KLECZKA. Thank you.

Mr. GOLDBERG. I would like to suggest a note of caution as the members of the committee consider the wisdom of relying extensively on competitive forces and avoiding at least for the short-term regulation.

The other day the GHAA reported the number of Americans receiving coverage through HMOs increased to 43 million from 40

million. That is a good sign, but we need to bear in mind the context here.

That means there are still more than 200 million Americans that are not getting whatever cost benefits are obtainable through that mechanism of health care delivery. And it is also the case that the staff or group model HMOs, which the Congressional Budget Office has said are the only ones that have demonstrated real efficiencies, still account for only 15.5 million Americans.

So if we are going to rely on competitive forces, we have to be very realistic about the pace of restructuring, because it is delivery system restructuring that drives efficiencies.

Dr. SIMMONS. Mr. Chairman, there is one other point——

Mr. KLECZKA. I think—Mr. Chairman, may I——

Chairman ROSTENKOWSKI. Dr. Simmons.

Dr. SIMMONS. Mr. Winters made a number of important points, but one I hope was not missed. It is a concern that we in our coalition have also, a concern about the massiveness of the alliances, how much of the total market they control.

We would also urge the committee to consider that carefully, because we do believe that could bring some problems that you don't need. And in that respect I think Mr. Winters and the Business Roundtable have made an important point for us all to think about before we lock in the size of those and how much of the market they could control. That is a piece of the cost-containment strategy, though not the direct subject of this committee meeting.

Mr. KLECZKA. Thank you very much.

Chairman ROSTENKOWSKI. Mr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Mr. Winters, I didn't quite understand the thrust and I want to clarify your testimony. We are trying to design a system for all Americans where everyone will get high-quality care. It sounds like you believe that there has to be different levels of care for certain members of society based on whatever—their knowledge, their information, their capacity to respond to information in written form and whatever—and that, therefore, you have to have more than one tier of health care and it should be decided by the providers which level of care people get.

Is that the basis——

Mr. WINTERS. If that is what you heard, then it sounds like I misspoke. That is not our intent at all.

Mr. MCDERMOTT. You said that people in ghettos needed certain kinds of health care as opposed to other parts of the society and, therefore, there essentially would be two tiers of care in this country—those people in the poor areas and those in the rest of the society.

Mr. WINTERS. That is not our intent. I referred in response to one of the earlier questions to a program which The Prudential has in Baltimore where roughly two-thirds of the participants are employees of private employers and one-third are Medicaid beneficiaries and they receive exactly the same care. We do not for an instant propose multitier care, two tiers or any other number of care for Americans.

Mr. MCDERMOTT. Ms. Wilensky, you oversaw Medicare, and I would make the assertion that the biggest problem you had in

Medicare is that you were one piece of the system and you couldn't control what was going on around you. It seems to me that the problems of Medicare could be solved if you had one system in which everybody was expecting the same kind of payment system in the fee-for-service or the same kind of treatment in a managed care arrangement since both pieces would operate under the single-payer system that you ran.

Is it your assertion that the problems can be fixed without having a single system where everybody has the same expectations?

Ms. WILENSKY. My assertion is that there are two directions we can go. I think either of them can work. I have a strong preference to one, not the one that you are suggesting. I believe if you have a very tightly controlled spending limit with pricing set by government or government's delegate, and you are prepared to enforce those spending limits, you can keep a rein on spending.

Mr. MCDERMOTT. What if prices are negotiated? You are making it unilateral. It is decided from the top they could be negotiated.

Ms. WILENSKY. They have to be established. They have to be consistent with whatever spending limit you have in place. If you are going to have a spending limit, you have to have price controls to enforce the spending limit. That is the only way you can assure that you can get to the spending limit that you have set.

What we have seen with European countries and with Canada is that they use two mechanisms to control spending. They have negotiated administered pricing consistent with their spending projections and a very tight handle on the diffusion of new technology in order to control costs. If this country is prepared to adopt that kind of system with administered pricing or pricing negotiated by government or whatever, to be consistent with spending limits and to control the diffusion of technology, we will get the spending that that implies.

I do not believe this country is going to do this based on what I have seen in the past, but I am willing to argue that if you adopt a tightly controlled system—no fooling, no safety valves—you will limit spending, but you better be clear about what you are doing.

Medicare is a good example. The incentives in Medicare are not good for moderating spending. You have well-insured, elderly people who have a lot of health care needs. Medicare pays 80 cents on the dollar for part B, a dollar on the dollar for part A, except if you fall outside certain extremes; 80 percent of the population has supplementary insurance; so consumers of Medicare services don't care a whole lot about whether they go to a cost-effective physician or hospital and the providers providing services for the most part don't have a lot of reason to hold back on services. This isn't quite true for hospitals now, because of DRGs. Hospitals have incentives to get patients into the less controlled outpatient setting. Physicians have an incentive to increase volume since most sources are provided under fee for service. This means providers of service don't have a strong incentive to do less and consumers of medical services don't have an incentive to go to cost-effective providers or to do with less. As a result we are constantly pressuring Medicare spending projections.

If you are serious enough about instituting a spending limit with no fooling around, what I believe Mr. Stark would do, and if these

limits were enforced, you would get spending to that limit. But if you are not prepared to do that, no fooling, then you better be sure that the incentives you have in place help you moderate spending.

Which is why I think you need to decide which direction you think this country will go or tolerate.

Mr. MCDERMOTT. The premium cap, which is essentially a capitation——

Ms. WILENSKY. No, it is a price control on a set of services.

Mr. MCDERMOTT. But how does that work? Why do you have more faith in that than in putting a list together and saying this is what you are going to pay?

Ms. WILENSKY. In terms of having people in capitated systems?

Mr. MCDERMOTT. Yes.

Ms. WILENSKY. It depends what else goes in the rate. If you have some of the changes that Jack Meyer mentioned, such as tax law changes where consumers pay for their health care with their aftertax dollars instead of pretax dollars and subsidize any people that need help because they don't have enough income in order to buy health care, capitation would moderate spending.

If people are buying a package of services, they are choosing whatever they think or you think they need. There are different people with different preferences who will go to groups that are going to provide services differently. Some will give you a better buy for your money than others.

For example, staff group model HMOs, because they are tightly organized and don't let you opt out and go to a physician outside their network, give you more benefits for your dollar and always will if they are run well.

I don't have an objection to capitation. I am much more concerned about what the lower end of our income population receives. If people want to buy more, I don't believe we should or will stop them from buying more.

Mr. MCDERMOTT. Is the Medicare level sufficient for the rest of the population? Would that be the minimum package that you would think would be adequate for the population and then they could buy above Medicare, everybody?

Ms. WILENSKY. Medicare is more than some need. There is a difference between which services are the right services and whether that means some third party has to pay them.

Mr. MCDERMOTT. I am just talking about the benefit package.

Ms. WILENSKY. Let me explain why that is important. I don't believe that a high-income individual needs to have the kind of Medicare-supplied coverage they now have. It makes no sense to me that we have to have the very highest-income elderly have a deductible of $100 on part B and 80 percent paid for by government thereafter with a 1 day deductible for hospital stays.

The notion of coverage for inpatient and outpatient physicians and for hospital services covered is appropriate for the benefit package, but the question of who ought to be responsible, to paying for these services, at what point coverage should begin is a different issue. I think coverage ought to vary with income; because I think what happens is we are not willing to spend what it would take to fund everything for everybody. What we end up doing is not funding enough for the lowest income. The result is we fund some

middle ground, that is much more than we really need to fund for the very highest-income people and not enough to help people right above Medicaid. We have helped Medicare with the QMB program and with Medicaid. We are now really covering all of the poorer elderly.

On paper at least we have a program that covers all of the poorest of the elderly. The problem is the people who are right above the poor, people at 120 or 150 percent of the poverty line. For a single person we are talking about $9,000 a year. Those are the people who get exactly the same government support as the $500,000-a-year elderly.

I know there are not a lot of super rich elderly, but it makes no sense to have a program like this unless you are willing to pay enough to cover everything for everybody. I don't believe we will do this. By not targeting who you help you end up giving too much to the wealthy and too little to the near poor.

Doing this doesn't have government make sure that everybody has exactly the same; instead government is making sure that people, who we as a society think need help, get help and that help varies with their income. To me, this makes much more sense.

I am really worried by who we miss. There are 12 million poor, uninsured. In a rich country like ours there is no way that you can justify this. No matter what you think government should do for nonpoor people, how can you possibly justify this?

Mr. GOLDBERG. A quick comment on a topic you and Ms. Wilensky were talking about a moment ago. I think the committee ought to recognize that there isn't such a sharp dichotomy between competition and regulation when we talk about health care reform. It may be useful to distinguish as we look at the health care system, very broadly between fee-for-service and the rest of the health care system, and to imagine having strict regulation as to the fees in the fee-for-service segment and allowing the rest of the health care system, organized delivery systems, HMOs, whatever we call them, to compete in effect below the ceiling established by the fee-for-service regulation.

That is to say, we could have a fusion of competition and regulation and as competition permeates the system more and more, per the suggestions of some of the folks on the panel, the proportion of the system subject to the fee regulation would decline over time and the proportion of the system subject to more unbridled competition would increase.

Mr. MCDERMOTT. With the indulgence of the chairman, Dr. Wilensky.

Ms. WILENSKY. As an economist, I think the notion that you could have regulatory and competitive systems working side by side makes no sense.

Mr. MCDERMOTT. Even though it is happening in Medicare?

Ms. WILENSKY. What you do is not have competition on price. You can't compete on price with administered pricing. Competition involves competition on a price and nonprice basis. If you have preset prices, as you do in Medicare, you can compete on things other than price but you can't compete on price.

When you set prices in Medicare, physicians and hospitals could come in underneath DRGs, a RBRVS value, that is, they could still

compete on price but they don't. Look at the records and tell me how many times there is price competition beneath the prices that are set. You may do many things, but you are not going to have competition as most economists use the term, which involves competition on a price and nonprice basis.

Mr. GOLDBERG. But it is in fact the case that the economic literature supports the proposition that HMOs do quite a bit of shadow pricing right now against fee-for-service plans; that is to say, they price below in effect a ceiling set by the prices of fee-for-service plans.

Ms. WILENSKY. Because of tax laws and other factors that don't push purchasers for people who go into HMOs to demand the kind of prices that they could and should.

Mr. MCDERMOTT. Thank you very much.

Chairman ROSTENKOWSKI. Do you have any closing comments?

Thank you very much. It has been most informative. We appreciate your sharing with us your views. I am sure we will see more of you. I hope we are smiling when we see each other.

[Whereupon, at 1:10 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

CAMARA DE COMERCIO LATINA DE LOS ESTADOS UNIDOS
Latin Chamber of Commerce of U.S.A.

WRITTEN TESTIMONY SUBMITTED

TO THE

HOUSE WAYS AND MEANS COMMITTEE

BY THE

LATIN CHAMBER OF COMMERCE OF THE UNITED STATES

DECEMBER, 1993

The Board of Directors and members of the Latin Chamber of Commerce of the United States (CAMACOL) have deep concerns about several features of President Clinton's proposed health care plan. As President of CAMACOL, I, Luis Sabines, have the duty to convey those concerns to you.

We are headquartered in Dade County, Florida, but have chapters elsewhere in Florida and along the eastern seaboard. While we represent a broad range of businesses, many members operate relatively small enterprises that, because of their on narrow margins, simply cannot afford a new Federal mandate to provide health insurance for very employee. Not only will the required health insurance payroll tax be too expensive, but the additional documentation requirements will strain severely our members' accounting and bookkeeping capacity.

According to a new analysis by the National Federation of Independent Business (NFIB), six of every ten health care dollars necessary fund the new Clinton plan would come from the business community.

The NFIB estimates that nearly all of the $ 29 billion in new employer health care spending would come from small businesses; most large companies already provide some form of health insurance for their employees.

As deeply unfair -- and as financially destructive -- as this health financing system might sound, many in the Hispanic business community will be struck even harder that other small businesses. President Clinton proposes to raise roughly ten billion dollars a year by more than quadrupling the federal excise tax on cigarettes.

The Administration claims the enormous tax hike will produce an "added benefit" by putting cigarettes out of the economic reach of low-income adults. Because they will no longer be able to afford cigarettes, low-income Americans will supposedly enjoy better health and will not place as heavy a burden on the new national health care system.

This simplistic, paternalistic and sanctimonious approach to Federal tax policy flies in the face Mr. Clinton's assurances as a candidate and as President to strengthen small and medium size businesses (as the source of the most new employment throughout the country). It also is contrary to pledges to relief low and middle income earners of inequitable tax burdens.

We are convinced that the adoption of a deeply regressive health care funding mechanism, such as an excise tax, will do great harm and in may cases destroy many small Latino businesses. Some of these are among the few providers of jobs and retail services in low-income communities across the nation.

We were led to believe that Mr. Clinton understood the problems of our nation's inner cities and small rural communities better that any recent President; but his proposed excise tax hike reveals that helping us solve those problems is not a priority of his administration.

The President seems willing, in fact, to make our problems much worse in order to meet his health care agenda.

Furthermore, the members of CAMACOL are saddened and frustrated by the inherent irony of the health care funding proposal: the government would ask the poorest members of society to pay the largest share of the costs of a health care plan that is purportedly meant to help them.

Raising the excise tax on cigarettes to 99 cents a pack from the current 24 cents would strike smokers with incomes below $10,000 a year up to 27 times harder than smokers earning more that $200,000, according to a recent study by the KPMG Peat Marwick accounting firm.

To stay in business and employ local residents, many CAMACOL members rely on cigarette sales, which will surely fall off precipitously if the price of every pack rises by 75 cents. Indeed, that is one of the Administration's stated reasons for the tax hike.

A large percentage of CAMACOL members also rely on low-income consumers, may of whom will have considerably less disposable income if the Clinton funding plan is adopted.

Proponents of the cigarette excise tax hike answer charges of regressivity and unfairness by admonishing people to quit smoking. But where would that leave the national health care system?

Under the current proposal, shortfalls in health care funding will almost certainly be made up by increasing the burden on business. The alternatives -- more severe rationing of health care or raising taxes on constituents -- seem far less likely to win favor with Congress.

President Clinton concedes that health care costs will continue to rise even if all of his proposed reforms become law. Tobacco use, on the other hand, is flat or declining in almost every demographic group in the country. Clearly, revenue shortfalls are inevitable if the government relies on cigarette excise taxes as a major source of funding for universal health care.

. . .

Thousands of jobs at or near the minimum wage level will be lost if cigarettes are singled out for a $10 billion annual tax increase. The newly unemployed will put added burdens on local, state and federal agencies that are already under severe fiscal restraint.

Business failures among our members and others will lower the local, state and federal tax base, further reducing government's ability to address the important problems we all face, from homelessness and illiteracy to illicit drug use and violent crime.

The members of CAMACOL strongly support the goal of reforming the national health care system. We admire the President's bold effort to turn back the rising tide of health care expenses. However, we trust the U.S. Congress to weigh the many options fairly.

We remain hopeful that the United States government can and will devise a new health care system with a funding plan that is fair, reliable and progressive.

Health care reform may be the most important Federal initiative since the New Deal. Let us live up to that example and craft a system that will serve our nation well for decades to come.

Luis Sabines
President
CAMACOL

TESTIMONY ON THE COST CONTAINMENT PROVISIONS IN THE HEALTH SECURITY ACT FOR THE HOUSE WAYS AND MEANS COMMITTEE

SUBMITTED BY GROUP HEALTH INCORPORATED (GHI)
1/5/94

Introduction
This statement is submitted on behalf of Group Health Incorporated (GHI), a not-for-profit health service corporation in New York State. GHI is the only not-for-profit health insurer actively operating statewide in New York. It is one of the largest not-for-profit health insurers in the state, with approximately two million subscribers and over one billion dollars in annualized earned premiums.

Throughout its 54 year history, GHI has adhered to its founding principle - that its policyholders are best served if they can receive accessible, cost-effective, quality health insurance. This is best done by utilizing networks of health care professionals who provide high quality health care services at cost-effective levels of reimbursement.

Support for Health Reform
GHI supports the principles embodied in the President's Health Security Act as well as many of its specific provisions. In particular, GHI supports the emphasis on guaranteeing that all Americans receive a uniform, comprehensive set of health benefits that is portable and affordable. It is good public policy, good for public health and good for the economy. It is good for the individual health and well-being of our citizens.

Issues Addressed by the Testimony
While the President's Health Security Act contains many positive points, it contains some provisions which, if enacted, would be problematic for insurers, providers and patients alike. In particular, GHI is concerned that the Administration's approach to cost control via limiting health insurance premium increases does not address the underlying causes of health care cost increases and only punishes the payor. Our statement touches on several critical issues in this regard. The areas addressed include: the appropriateness of the budget limits set in the Health Security Act; how realistic these limits are; whether effective incentives can be created to encourage health plans to control costs; and possible unintended consequences of the Administration's approach to controlling costs.

A. Are the budget limits in the Health Security Act appropriate, consistent with maintaining quality of care while expanding access to health services?
Currently, there are no objective criteria for determining an 'appropriate' level, or rate of growth, in health care spending; consequently, there can be no objective criteria for determining an appropriate level, or rate of growth, for health insurance premiums. The Clinton Administration's plan to link future increases in premium rates to the increase in the Consumer Price Index (CPI) is inappropriate. Such premium limits are arbitrary. The proposal makes no allowances for initially setting and updating premium rates that reflect changes in population age, demographics, casemix, the need for medical care, or changes in health sector specific price inflation, technology and productivity.

The caps within the President's proposal would limit premium increases, after a three year phase-in, to growth in the population plus change in the Consumer Price Index (CPI). Premiums are currently rising 12 percent per year, compared with a general inflation rate of 3 percent. (1) This is a tight lid. Under such arbitrary caps, the limits would be driven by federal budget priorities that have little if anything to do with health care. Any decision making in health care that is based mainly on government budgetary needs and not on patient needs is not in the best interest of patients. It will lead to rationing.

A recent report by the Congressional Budget Office noted that "Effective limits on premium increases would affect both the quality and quantity of health insurance coverage and their future access to new medical technologies." (2) A spending limit based on economy-wide inflation plus population growth would be very difficult, if not impossible to meet, without either reductions

in volume or price increases substantially below the increases necessary to cover case-mix changes and projected input cost increases. This would translate into reductions in the number or types of services available, resulting in longer waiting times for some tests and procedures. The quality of services will certainly suffer. When prices are fixed below free-market levels, providers characteristically respond by lowering the value of their services to the depressed price. A logical reaction of hospitals and other health care providers will be to get along with fewer nurses and technicians per patient, and restrictions on expensive life-saving treatments.

If health care spending growth is to be brought in line with the growth in the general economy, American consumers simply will not be able to 'have it all'. Although the health plans would likely yield some efficiencies, such as lower administrative costs and greater use of managed care, continuous spending cutbacks will eventually translate into some limitation on access to health services, particularly with regards to medical technology.

These problems may not appear immediately. What is insidious about price controls on health care is that there will be a long lag before you begin to see an impact on the supply and quality of service. In the short term, you may see a decline in the rate of growth of health care expenditures and it might appear that the controls are working.

After five or ten years, however, we will begin seeing the impact as a restricted supply of medical services results in longer waits for physician care, greater difficulty in being admitted to a hospital bed, and a slowdown in the development and spread of new technology. Similarly, hospitals won't turn into warehouses overnight, but price controls will mean fewer hospitals will be built, with less investment in, and maintenance of, the existing ones. In other words, price controls, in the form of premium caps, will mask the lack of investment and the consumption of capital.

B. Is the projected declining rate of growth in health spending, as outlined in the Administration's bill, realistic?

GHI believes that it is unrealistic to assume that the rate of health care cost inflation can be held to the same rate as general inflation (as measured by the change in the CPI) over an extended period of time.

Health industry input prices are rising faster than general inflation and the difference is not being offset by higher productivity growth in the rest of the economy. Coupled with growing demand (caused in part by an aging population and improved technology), health care cost inflation will have to rise faster than inflation in the larger economy. Nothing in the President's Health Plan directly addresses these prime causes of health care cost increases.

Instead, after a three year phase in, growth in insurance premium rates will be limited to the percentage change in the CPI plus population growth. Data from some of the Organization of Economic Cooperation and Development (OECD) countries shows how difficult it would be to achieve this goal. According to the OECD figures for the years 1985 - 1991, for example, German health care expenditures grew annually at 2.9% above inflation, the Canadian single payer system grew annually at 4.8% above inflation, and the British nationalized system grew annually at 4.1% above inflation. In other words, none of the industrialized countries have been able to limit increases to general inflation, even with global budgets, administered pricing, and a tight control on technology. (3) With the annual population growth projected at less than 1%, after adjusting for inflation, the Administration would allow U. S. health expenditures to grow at less than 1% per year after the year 2000, with no real per capita growth permitted.

The best way to bring the rise in health care costs in line with the general rate of inflation would be to increase the productivity of the health care workforce. But health care is an example of what the economist William Baumol calls a 'handicraft service', which can't be automated or sped up to be made more productive. While doctors can probably work more efficiently, they cannot work much faster than they currently do without a reduction in quality. (4)

On the other hand, while technological increases have not led to an increase in productivity, it can be argued that they have led to great increases in quality and positive outcomes, which are rarely noted in discussions about cost increases. In other words, many quality and outcome

changes are mistakenly viewed solely as price changes. (5) For example, the health services CPI component is based on the separate prices of both inpatient and outpatient services. But little or no emphasis is placed on the changing quality of these services. With regard to outpatient services, as surgeries are shifted from inpatient to outpatient settings, the average complexity of the procedures in each setting increases because the procedures shifted from the inpatient setting are both less complex than the average inpatient procedure and more complex than the average outpatient procedure. Those patients who are admitted as hospital inpatients are now 'sicker', on average, than patients admitted ten years ago as the 'healthier' patients are now often treated on an outpatient basis. Thus, today's hospitalized patients, while fewer in number, consume more services, on average, than earlier patients. Patients in both settings also consume a different mix of services than ten years ago, as technological advances have made new devices (e.g. lithotriptors) and procedures (e.g. laparoscopic surgery) available that did not even exist a short while ago.

C. Can effective incentives be created to encourage health plans to control costs?
When thinking about medical costs, it is important to distinguish the level of costs from their rate of increase. There is evidence that the level of costs is too high (i.e., rates of inappropriate surgery) ; there is less evidence that the rate of increase is too high, as shown by the fact that high rates of increase in the costs of medical care can be found even in those industrialized countries that have some form of nationalized health insurance.

The Plan does create effective incentives to encourage health plans to contain costs over which they have control. This can be done by utilization controls, such as utilization review and provider profiling; the management of expensive cases into the most appropriate modality of treatment; changing the locus of care to more cost effective modalities (i.e., the trend towards doing cataract surgery on an outpatient as opposed to an inpatient basis); and changes to increase the administrative efficiency of the medical care system.

But it is important to note the kinds of costs that health plans do not have control over. Costs of this type would include the aging of the population, improved technology and other factors that would increase utilization, such as providing health insurance coverage to those currently uninsured. The health economist Joseph Newhouse persuasively argues that the enhanced capabilities of medicine have probably accounted for most of the increase over time in real per capita health care costs.(6)

This issue of costs a health plan has control over and costs it does not have control over is crucial, particularly if the assumptions of what are controllable versus uncontrollable cost are incorrect. Essentially, there are two major components in a health insurance premium. First, and the one over which health plans have the more direct control, is administrative costs. This is composed of such things as salaries, marketing costs, costs of computer systems, rent and other fixed costs, and the development of new products and expenditures for customer service activities. For a not-for-profit company like GHI, this component represents approximately 10% of earned premiums. These costs can be directly controlled by employment decisions and decisions on when and how to invest in new technologies. A health plan can, and should, be held accountable for the growth in such costs.

There is, however, the other 90% of the premiums over which health plans have less control. This is known as the claims cost. This is the money spent on reimbursing physicians, hospitals, pharmacies and all the other providers of health care for services rendered to a covered population. The increase in cost here is due to several factors, some of which GHI can control, such as the rate of growth in unit costs. GHI negotiates with its participating providers and it does a good job of controlling this component of the claim cost. GHI uses preferred provider networks for certain specialty care needs and does utilization review to assure the appropriateness of care. However, there are other components over which GHI has little or no control. For example, every year the population base ages. With the coming bulge of 'baby boomers' reaching middle age, there will be a substantial growth in the number of elderly people over the next two to three decades. This will have a disproportionate impact on the rate of growth in health care costs as the elderly use, on average, more in the way of health care services than do younger people.

In addition, a substantial percent of the amount spent on health care is concentrated on relatively few seriously ill patients. A study examining this phenomenon found that, in 1987, the top 1 percent of the U. S. population, ranked by health care expenditures, accounted for 29 percent of all such expenditures. The top 10 percent of this population accounted for 75 percent of all expenditures. The bottom 50 percent of the population accounted for only two percent. (7) While active medical case management programs, like those employed by GHI, can help control costs for these seriously ill people, while ensuring that they receive appropriate care, the costs of treating such illnesses will continue to grow as medical technology continues to advance medicine's ability to keep these patients alive for even longer periods of time.

Also, throughout much of the last decade, hospitals have upgraded the skill mix of their employees in response to the growing use of technology in the provision of health care services. RNs were required instead of LPNs, and there were increases in the proportion of medical technologists, radiological/nuclear medical technologists and respiratory therapists within their respective departments. The main point is that much of the rise in costs is due to the aging of our society and the increased use of technology. These factors are largely beyond an insurer's control unless society makes a decision to limit the availability of expensive new services or decides to limit such services to the very ill.

Finally, an examination of earlier attempts at price controls provides some information on the effect this approach has had on controlling health care costs. A recent report commissioned by the Prospective Payment Assessment Commission found that as a result of the freezes and limits imposed on the health care industry from 1971 to 1974, the rate of increase in overall health care costs dropped a modest one percentage point. (8) It is generally agreed that most of the impact of the Economic Stabilization Program came as a result of reduced rates in hospital spending without much offset of untoward volume increases. The study mentioned that the moderation in the rates of increase in health care prices during this time were largely attributable to a lagged response to trends in national income level and price levels rather than to the application of controls per se. Furthermore, during this time, other regulatory initiatives, such as hospital certificate-of-need programs, were starting to take root, making it harder to trace spending reductions to a single cause.

In the current environment, it is reasonable to assume that such controls, in the form of a cap on insurance premiums, will be even less effective. First of all, the fact that hospitals and other health care sectors have been exposed to many years of cost containment and volume control pressures argues for smaller effects of a wage/price control program today. Second, unlike the wide ranging wage and price freezes imposed during the Nixon Administration, the current proposal centers on making health insurance premiums the only segment that would face such controls. Under the Nixon era freezes, it was easier for hospitals and other providers to absorb price limits because the increases in costs of the goods and services they bought were also suppressed.

Based on the above information, it is reasonably accurate to assume that the Clinton Plan will lead to some reduction in the level of costs, with little reduction in the actual rate of cost increases.

D. What are the possible unintended consequences of the Administration's approach to controlling costs?

The Administration's plan to control costs through the use of insurance premium caps will lead to several unintended negative consequences:

First, the price control aspects of the Plan will discourage needed investment in the very health networks that are essential to the Plan's success. Premium caps would work against the continued development of integrated, network based managed care plans, which GHI and the Administration believe are the best hope for health care cost containment. Developing managed care networks requires significant up-front investment to identify appropriate network participants, establish utilization management programs, and develop and implement data systems. Premium caps would discourage investors from supplying the capital needed for these investments.

In addition, moving to universal coverage will require insurers and health plans to attract more capital investment, both to expand their service networks and to maintain statutorily required reserves. Further, these caps will be applied at a time when insurers and health plans are being required to enroll many currently uninsured individuals and small employer groups. These populations often have significant unmet health needs.

At this time we should be investing capital in promoting health care reform - replacing acute care inpatient rooms with expanded outpatient treatment centers; converting hospital bed space to other health care uses; expanding free standing primary care sites; and linking physicians, hospitals, nursing homes, and home care agencies into collaborative, patient centered health care networks. But it will be difficult to make these investments when premium caps are going to squeeze out any incentive for innovation.

While the Administration may argue that health care companies can earn adequate returns by cutting costs due to waste and inefficiency, this has already been substantially accomplished. Much of the waste and inefficiency currently discussed was wrung out of the system long ago. Easily achievable gains in efficiency have already been found.

Second, premium caps will dampen medical research and innovation. Under cost controls, the expected rate of return from new services and equipment needed to justify major investments in research and development may decline. The flow of basic and applied research and technological innovation will hinge on the expected rate of return. While such work would not come to a complete stop, the rate and flow of such innovation is likely to be affected.

Another unintended negative consequence of the Plan is that it has the potential to induce other forms of medical underwriting. Health care reform that relies on competition among health plans should discourage health plans from competing on the basis of risk selection rather than on effective management of costs. But health plans, by virtue of where they are located, will attract higher or lower risks. Actual costs per person will differ among the alliances despite the fact that the benefit packages offered will be the same. Under premium caps, additional pressures will be put on insurers to find ways to cut costs, and one way to do this under the current reform proposal would be to skim patients by geography, by locating in alliance areas with lower risk populations. Alliances and plans that cover the inner city poor will be saddled with the highest premiums and higher annual increases in costs. Unless the proposed risk adjustment formulas in the Administration's health plan can be effectively implemented, there will be strong pressures for health plans to avoid locating in alliance areas with relatively larger percentages of high risk patients.

Finally, the adoption of premium caps would lead to the failure of many health plans, for reasons that have little to do with efficiency and quality. It is one thing to penalize a health plan for costs over which it has control. It is another to penalize a plan over things that it cannot control.

GHI is currently undertaking an analysis of the impact the proposed premium caps might have on the financial position of the company. What follows is a preliminary estimate assuming the Clinton health plan had been fully implemented and in effect from 1990-1992. The assumptions made are simple: premium increases for those years were held to the increase in the CPI. Claim costs, which at GHI increased less than the average observed increase in New York, were not capped. The results were dramatic. In 1992 GHI's statutory reserve was $59 million. By 1992, if Clinton's premium cap had been fully implemented, GHI would have experienced a cumulative deficit of about $400 million for the period 1990-1992. Even if the regional alliance inflation factor, adjusted for material changes in demographic and socio-economic characteristics of the population of alliance eligible individuals and other adjustments provided for in the Plan were taken into account, GHI's actuaries estimate the ultimate impact would have been the same - the company would have been in a significant deficit position by the end of 1992.

If a company as cost-effective as GHI, with its negotiated reimbursement methodologies and low administrative expenses, faces these significant adverse consequences as a result of the proposed premium cap, many insurance companies will likely find themselves driven from the market.

That will cause the loss of jobs within the health insurance industry and a decrease in the number of health care plans consumers can choose from.

Conclusion

The President's Health Security Act is an ambitious program for restructuring the nation's health care system. GHI supports the broad goals of the Plan, in that it provides a unified system to cover all Americans, relying largely on the existing foundation of employment-based health coverage. But the Plan may be optimistic in its claims of maintaining access and quality while controlling costs. While some aspects of the plan's cost containment approaches may be successful, the Plan's approach to cost control may have the unintended consequences of discouraging capital investment in, and by, health care plans; dampening medical research; and lead to the failure of health plans.

Footnotes

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(2) Ross, M. N. 'Controlling the Rate of Growth of Private Health Insurance Premiums.' Congressional Budget Office, September, 1993.
(3) Statement of Gail Wilensky before the Committee on Ways and Means, House of Representatives, December 16th, 1993.
(4) Baumol. W. 'Reform Can't Cure High Costs' The New York Times, August 8, 1993, p. 13.
(5) Mundel, D. S. 'The Inadequacies of the Health Care Services Component of the CPI' Medical Benefits, Vol. 10, No. 21, Nov. 15, 1993, pp. 7-8.
(6) Newhouse, J. P. 'An Iconoclastic View of Health Cost Containment', Health Affairs, Vol. 12, Supplement, 1993, pp. 152-171.
(7) Finkler, S. et. al. 'High Cost Users of Medical Care', Health Care Financing Review, Summer, 1988, Vol. 9, No. 4, pp.41-52.
(8) Prospective Payment Assessment Commission. Analysis of the Effect of the Economic Stabilization Program. Extramural Report E-93-04, May, 1993.

STATEMENT OF LINDA F. GOLODNER, PRESIDENT
NATIONAL CONSUMERS LEAGUE

Mr. Chairman and members of the Committee, over 94 years ago, the National Consumers League (NCL) was founded by a group of Americans concerned about protecting the rights of citizens in the workplace and marketplace. Since that time, NCL has grown into a national organization representing thousands of consumer activists across the nation on issues ranging from state and federal consumer protection legislation to fair labor standards for child labor.

Over our 94 year history, NCL members have often voiced their concern about the failure of our health care system to adequately protect all Americans. Despite the passage of Medicare and Medicaid legislation in the mid-1960's, over 37 million Americans have no health insurance protection. Millions more have limited protection, and virtually all Americans live in fear of losing their jobs and the vital health insurance benefits that go with employment.

Even for those who do have high quality health insurance protection, the costs of those policies have been skyrocketing. The $752 billion spent on health care in 1991 was equivalent to approximately $7,860 for each of the 96 million American households or over half the annual income of more than 24 percent of all households.

Moreover, the distribution of health care spending among households is grossly unfair. According to a recent study by the Economic Policy Institute, low-income families pay over twice the share of income for health care as do high-income families. Out-of-pocket spending is particularly regressive with low-income families spending nearly nine times the level of high-income families as a share of income.

The National Consumers League Board of Directors established a set of principles to guide our policy on health care reform. These principles address the problems described above as well as the need for greater consumer involvement in the health care decision-making process. Health care reform, whatever specific form it takes, must create a system that assures access to affordable, quality care for all Americans and controls cost. While medical care itself is inevitably technical and therefore must be left to physicians and other qualified health care providers, it is important that consumers be genuine participants in their own care and have a significant role in shaping public policies which affect them and their families. The principles that the National Consumers League sets forth are:

- Prevention and the promotion of health lifestyles must be essential components of health care reform.

- Primary health care should be the foundation of the system. Consumers should be able to receive care from a full range of quality providers, including physicians, nurses, pharmacists, dentists, nutritionists, and mental health workers.

- Attention must be given to populations with special needs such as children, pregnant women, the poor, people with HIV and AIDS, the elderly, people with mental and physical disabilities, and non-English speakers.

- There must be a strong emphasis on the development of physician practice guidelines and nursing research based on health outcomes.

- A network of care should be available to persons living in underserved urban and rural areas to coordinate an often fragmented health delivery system, often complicated by

inadequate communications and transportation systems.

- Long-term care must be an essential feature of reform. It should be integrated with acute health care services and should be available in the most appropriate setting.

- Health care financing must be progressive and based on a uniform payment system with community rating. Deductibles, co-insurance and copayments are obstacles to full access to the health care system and should be eliminated or at least held to a minimum.

- Programs should set specific prices for health care services, and providers should be prohibited from requiring consumers to pay additional fees.

- Consumers must have access to comprehensive and accurate information and education about the range and implications of available health care options.

- Managed-care systems, including Health Maintenance Organizations, should be a choice for consumers and participation should be on a voluntary basis.

- The new health care system should require a safe environment in workplaces, the proper disposal of industrially-related toxics, and research on occupational health hazards. Workplaces that are dangerous or expose employees to long term health risks impose substantial burdens on the system.

- Dissemination of new medical technologies without adequate assessment of effectiveness re requirements for training and teaching is harmful to the quality of medical care and greatly adds to the cost.

- Advertising of prescription medications should be carefully monitored and regulated.

- Consumers must have the right to an appeals process to contest unfair administrative or medical decisions.

- Patients should have unrestricted access to their medical records and they should have a right to correct inaccurate information and to control dissemination of confidential information.

- Consumers must be represented in either an administrative, advisory, or advocacy capacity at every level and in every sector of health care.

The Health Security Act

The recent introduction of President Clinton's Health Security Act is a major step forward in the process leading to comprehensive health care reform. The President's commitment to universal access to health insurance for all Americans is a critical component of reform. Although the employer mandate included in the plan will be controversial, NCL strongly supports this method of assuring health insurance coverage to the millions of Americans who today are uninsured.

In addition, we commend the President for provisions of the plan designed to slow the dramatic increases in health care costs that have plagued the current system for the past two decades. Although many insurance companies will oppose these provisions, we view limits on increases in health insurance premiums as a core element of the Clinton plan. The insurance industry has been a part of the health care cost crisis for too long, now they can become part of the solution.

The President's plan also recognizes the importance of greater consumer involvement in the health care decision-making

process. The establishment of consumer advisory boards to assist the health alliances in determining which health plans best meet the needs of consumers can be invaluable in assuring consumers access to the best possible plans.

However, we would caution that such advisory boards must have the means to be effective advocates for consumers. Too often such boards are set up as "window-dressing" with no real access to information essential to making informed decisions. NCL would urge that provision be made for these boards to have sufficient resources -- both in terms of staff and financial assistance -- to play a major role in working with health care alliances.

Financing Health Care Reform

As the EPI study points out, the current health care system is highly regressive. NCL believes that reforming our payment system to make it more fair to low-and middle-income consumers is an important element of health care reform. In the area of financing, we believe the Clinton health care plan can be improved.

First, the plan relies very heavily upon flat premiums to be paid by employers and employees for much of the funding. These premiums would remain the same for an employee making $15,000 and for the employee making $150,000. If the cost of an average policy in the U.S. is $4,000, the family making $15,000 would pay 27 percent of its income for health care, and the family making $150,000 would pay less than 3 percent of its income for health care. Although the plan does include subsidies for the very poor, the inequities of premium financing cannot be fully addressed in this manner.

In addition, the Clinton plan calls for a dramatic increase in tobacco excise taxes to pay for part of the program. Excise taxes -- whether broad based value added taxes or narrow tobacco taxes are highly regressive. According to studies done by Citizens for Tax Justice, an excise tax on tobacco takes a 72 times greater share of income from a family of four in the lowest 20 percent of the income distribution than it does from a similar family in the highest one percent.

Taken together, the Health Security Act's reliance on flat premiums and excise taxes may do very little to improve the regressiveness of the current health care system. We urge the committee to look closely at the distribution of health care costs under the Clinton plan and find ways to make the program's financing mechanisms more equitable for low- and middle-income consumers.

Conclusion

The National Consumers League strongly supports many elements of the Health Security Act. Provisions of the plan designed to assure universal access and cost containment are critical to successful reform of the current system. Our members and all health care consumers have a tremendous stake in reform and will work actively to assure that these provisions are included in the final law.

However, we also believe that consumers must be encouraged to play an effective role in the new health care system and that the bill can be strengthened to assure their participation as full partners with the health alliances. In addition, we urge the Ways and Means Committee to find ways to improve the progressivity of the Clinton plan.

STATEMENT OF MICHAEL R. LOSEY, SPHR
PRESIDENT AND CEO
SOCIETY FOR HUMAN RESOURCE MANAGEMENT

The Society for Human Resource Management (SHRM) is the leading voice of the human resource profession, representing the interests of more than 56,000 professional and student members from around the world. SHRM provides its membership with ongoing government and media representation, education and information services, conferences and seminars, and publications that equip human resource professionals to become leaders and decision makers within their organizations. The Society is a founding member and Secretariat of the World Federation of Personnel Management Associations (WFPMA) which links human resource associations in 55 nations.

Undoubtedly, the issue of health care reform is one of the most important challenges facing the nation, the Congress and the human resource profession. As both consumers and purchasers of health care, the more than 56,000 members of the Society for Human Resource Management (SHRM) are confronted with the difficulty of providing health coverage to their employees while managing the escalating costs to their businesses. Therefore, SHRM is excited about the prospects for reform of our nation's health care system. However, we are equally concerned about the shape that the reform will take. As your Committee continues to refine the details of the President's "Health Security Act" (H.R. 3600) and to examine alternative health proposals, real world experiences of human resource managers in designing employee health plans will provide invaluable information. Since human resource practitioners will be responsible for implementing and integrating new health care reform requirements with existing benefits plans, SHRM is uniquely suited to provide practical insights on the effects of the proposal.

First of all, SHRM would like to commend President Clinton and the Administration for their efforts to address the critical and complex issue of health care reform. We appreciate the goals of security, simplicity, savings, choice, quality, and responsibility. However, since the devil is often in the details, we would like to offer the following specific comments on the proposal based on the framework of health care principles approved by our Board of Directors in 1992:

I. Basic Benefits Package

SHRM believes that the basic core of health care services should emphasize preventive care and commends you for including preventive care in your package. SHRM is concerned, however, that design of the basic benefits package is too generous and does not carefully consider the costs of providing these benefits.

II. Purchasing Pools

SHRM believes that small employers should be encouraged to form risk sharing groups to obtain affordable coverage. The government should provide incentives and/or sponsor public/private vehicles for risk sharing and/or insurance. While SHRM supports the creation of purchasing pools to give small businesses more bargaining power, SHRM believes more than one health alliance should be permitted in a geographic region so that employers have a choice of a purchasing agent. SHRM supports allowing multiple competing health alliances within an area and permitting smaller employers to band together to form a competing health alliance.

In addition, the Health Security Act's requirement for most employers to purchase coverage through the health alliance would negatively affect many mid-size employers who are currently self-insured. As proposed, we believe that the 5000 employee limit is far too high, affecting only a handful of employers, while disenfranchising thousands more.

III. **Corporate Alliances/ERISA**

SHRM believes that the Health Security Act would discourage employers from electing to maintain self-insured plans or negotiating directly with a health plan. Only employers with more than 5000 employees who elect to establish a corporate alliance to maintain self-insured plans would qualify for an exemption under the Employee Retirement Income Security Act (ERISA). ERISA would be amended to require corporate alliances to meet new federal guidelines. In addition, the statute would be amended to permit taxes and assessments on corporate alliances.

SHRM strongly opposes this erosion of ERISA preemption. National health care reform should include a uniform set of federal rules and regulations and should apply to those purchasing health care, rather than the wide variations existing from state to state. Rather than being reduced, we believe that preemption under ERISA should be expanded to address all health standards. Health care plans and the laws that apply to them are complex enough. Employers who want to expand regionally or nationally should not be inhibited from doing so by a maze of conflicting state requirements. Further, employers currently self insure to better manage the costs of their plans and meet their employees' needs. Under President Clinton's plan, employers would no longer have this control over the design of their plans.

IV. State Authority

Under the Health Security Act, ERISA would be amended to permit any state or part of a state to establish a single payer system of health care. This provision would allow the federal government to waive ERISA requirements and other rules governing corporate alliances, thereby eliminating corporate alliances in states or parts of states.

SHRM opposes health care reform provisions that would give states a "blank check" to disregard federal directives and impose their own version of health care on the employers located within their borders. Specifically, SHRM opposes granting states the authority
to establish a single-payer system of health care at the federal/state level. Such a system would eliminate the competitive forces of an employer-based system which can promote quality and reduce costs.

Under President Clinton's plan, it is likely that additional state regulations would affect employers. For instance, states could require plans to provide benefits in excess of any federal standard benefits package. Health alliances could be run by the states, and states could impose taxes on provider services which could be passed on indirectly to employers and employees.

Many SHRM members work for self-insured companies with operations in multiple states and are concerned that under the new system they will have to begin complying with a patchwork of state laws.

V. Employee Contribution

We strongly believe that incentives should be provided to encourage payers and patients to act as consumers in choosing health care services that are cost-effective. Deductibles, co-payments and reasonable contributions by participants should also exist to encourage individuals to make consumer-like decisions about health care. Specifically, employees should be required to make some level of copayment. This would help to prevent the utilization of health care services from rising uncontrollably as coverage expands. Therefore, the level of employee copayments and deductibles should be high enough to discourage unnecessary utilization of health services.

VI. Taxation of Benefits

The Health Security Act would permit employers to continue to deduct the cost of the basic benefits package as a business expense. The cost of additional benefits would be taxable as income to employees after a 10 year grandfather clause. Section 125 or "cafeteria" plans would be amended to exclude employee contributions for health benefits.

SHRM believes the tax structure should encourage payers and patients to act as consumers in choosing health care services that are cost effective. SHRM strongly supports the continuation of Section 125 benefit programs since they encourage employees to plan for their medical expenses.

VII. Workers' Compensation

Initially, the Health Security Act would require that workers' compensation related health care treatment be provided through the state-certified health plans. These health plans would designate a case manager to handle job-related injuries and illnesses and adopt certain treatment guidelines for handling workers' compensation cases. In addition, a new Commission would be established to study the feasibility of fully integrating the medical part of workers' compensation with the health care system and make recommendations by 1995.

SHRM is in the process of developing a position on the coordination of the workers' compensation and health care systems. However, any reform should not result in cost-shifting to the payers who reimburse the costs of care for job related injuries and illnesses. Changes should not jeopardize the existing incentives for safety nor affect the exclusive remedy. Also, any system should help employers control indemnity costs by encouraging employees' rapid return to work.

VIII. Malpractice reform

The Administration's health plan would establish a mandatory, non-binding Alternative Dispute Resolution (ADR) mechanism to settle complaints. Attorneys' fees would be limited to a maximum of 1/3 of an award and states could impose lower limits. It would also establish a pilot program of practice parameters to set guidelines for appropriate care and establish grant programs for state demonstration projects in enterprise liability. It does not, however, set any limits on punitive damages which contribute to the high costs of malpractice.

SHRM believes that reform of the medical malpractice system could contribute significantly to the reduction of health care costs. Any comprehensive health care reform proposal should improve this system to avoid wasted energy and money spent on unnecessary "defensive" medicine and litigation.

IX. Insurance Reforms

The Administration's plan would prohibit preexisting exclusions and waiting periods. Plans would not be able to terminate, restrict or limit coverage for any reason, including non-payment of premiums, and a system of community rating would also be established.

SHRM supports insurance reform provisions which address portability, risk sharing, and community ratings, particularly in the small market.

X. Employer Mandate

SHRM believes that employers should not be required to pay for a portion of their employees health premiums -- particularly not an amount as high as 80 percent as proposed by the "Health Security

Act." According to the Employee Benefit Research Institute (EBRI), would result in a net loss of 168,000 jobs. Other academics and organizations estimate an even higher number of jobs lost.

SHRM believes that the solution to the problem of the uninsured depends on the careful coordination and planning of all concerned parties. We endorse the continuation of an employer-based system. We believe that the problem of the uninsured is a societal problem and not a problem solely to be resolved by employers and other private payers. Accordingly, SHRM opposes pay or play proposals which require an employer to either provide coverage to their employees or contribute a percentage of their payroll to a
government insurance fund. SHRM strongly opposes any proposal that imposes a mandate on employers as the sole solution to health care reform.

XI. Individual Obligation

According to the Administration's proposal, it is the obligation of every individual to enroll in a health plan. Therefore, anyone who does not meet the established deadline for enrollment is automatically enrolled in a health plan when they seek medical care.

SHRM recognizes that the costs of unpaid health care for the uninsured and the underinsured result in increased health care costs to the private sector. By requiring all individuals to have health coverage, the costs to the insured of treating the uninsured would be reduced. SHRM believes that a strong disincentive should be provided to prevent individuals from postponing enrollment in a health plan.

XII. Health Plans

As we understand the "Health Security Act", every employee would have a choice of at least three health plans each with a point-of-service option.

SHRM believes that the use of managed care programs should be expanded. Managed care allows employers, providers and employees to reduce health care spending together. There are various types of managed care programs, and employers and employees could decide which type is best suited for their specific needs.

Employers of all sizes have been able to provide sound and informed choices for their employees. While the goal of presenting several options to employees is laudable, any health reform proposal should enable employers to meet the information needs of their employees without creating unnecessarily complex administration and communication requirements.

In general, while the low cost-sharing plan should indeed cost employees less than high cost-sharing plan, its pricing and the reporting of qualitative measures must still promote consumer-like behavior.

XIII. Cost/Financing

SHRM believes that health care reforms should be based on a model which has built-in incentives to balance both quality and cost-efficiencies. Any cost-containment proposal should contain measures to eliminate cost-shifting. SHRM is concerned by criticism of the Administration's financing mechanism and will evaluate the financing mechanism of any health reform proposal since inadequate funding will lead to further cost-shifting.

In conclusion, SHRM recognizes that there is no panacea for health care reform. It is a system that requires comprehensive

reform and the compromise of all parties involved. Accordingly, we urge you to consider the concerns of human resource experts throughout the next several months as you debate the details of President Clinton's proposal and seek to understand the real world effects of this and other health-care reform proposals. We would be happy to work with you to provide information on our members real life experiences with the health care system. I hope that you will contact the Government and Public Affairs Office at (703) 548-3440, ext. 3608 if we can assist you as you continue to consider the important issue of health care reform.

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ISBN 0-16-044197-8
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